IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B., CARRIE G., JOSHUA M., MEAGAN A.) and ERICA A., by their next friend, L.A.; DUSTIN P. by his next friend, Linda C.; BAYLI S. by her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,

Plaintiffs,

v.

NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services

Defendants.

No. 3-98-0168
Judge Nixon

JANUARY 2003 SEMI-ANNUAL PROGRESS REPORT

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B., CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTIN P. by his next friend, Linda C.; BAYLI S. by her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)	
Plaintiffs,	)	
v.	)	No. 3-98-0168
	)	Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)	
Defendants.	)	

JANUARY 2003 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel regarding their compliance with the terms of that order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable

audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order . . ."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending January 31, 2003. Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' counsel.

Respectfully submitted,

PAUL G. SUMMERS
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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been forwarded by first-class U.S. Mail, postage prepaid, to:

Gordon Bonnyman
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on this, the 31st day of January, 2003.

Linda A. Ross
LINDA A. ROSS

John B. Semiannual Progress Report
January 31, 2003

Between August 1, 2002 and January 31, 2003, the state has continued a host of EPSDT activities amidst the implementation of a new TennCare waiver. Each state department or division has played an active role in the EPSDT effort and has actively coordinated efforts to best serve children.

Each department/division involved in the EPSDT program spent a significant amount of time and resources on a response to the Special Master's Itemized Assessment Protocol (IAP). On October 16, 2002, the State submitted a coordinated response to the Itemized Assessment Protocol, followed by the submission of an initial work plan on December 12, 2002.

This report was also a coordinated effort and reflects the EPSDT activities by department/program/division which together form the State of Tennessee's EPSDT program.

Sections of this report and the pages on which they begin are as follows:

Part I: Quality Oversight: EPSDT Outreach and Screening Activities

Each MCO is required to send a monthly report on EPSDT and to include in this report their outreach activities for the month. Dr. Ken Okolo, Director of Quality Oversight, has discussed possible solutions to increase compliance rates and EPSDT systems for collecting program data for tracking and reporting all EPSDT activity. The importance of training and educating providers and their office staff has been discussed. Managed Care Organizations (MCOs) have been advised by Dr. Okolo to educate their providers in EPSDT to include all the components necessary to complete a preventive screen visit. During medical record reviews the Quality Oversight staff gives each provider and/or office staff a video which describes the components of an EPSDT screen. The Quality Oversight staff also gives the provider a copy of the age specific preventive screening forms. These screening forms have been proven to increase documentation of screening rates and all providers are encouraged to utilize these forms.

All health plans have made efforts to inform their enrollees regarding EPSDT benefits. The efforts include:

Xantus Health Plan

Xantus Health Plan now has the ability to track each child and monitor the receipt of required screening, diagnosis, and treatment. A newly developed EPSDT tracking system is being utilized to assist case managers in the tracking and follow-up of members not receiving EPSDT services. Medical providers whose assigned enrollees do not have EPSDT services documented are identified and tracked. Contacts with providers and gaps in performance are also tracked. Members/parents/guardians are being notified regarding the need to make an appointment and receive EPSDT services.

TLC

Memphis Managed Care (TLC) has demonstrated extensive efforts at outreach to improve their compliance rates. They expanded outreach efforts to include Disease Management Specialist, Case Managers and attending physicians. TLC is considering extra incentives for provider's office staff for appointments kept for preventive screening. An automatic dialer for telephone outreach was investigated. TLC plans to develop a notice to providers showing the financial impact of compliant EPSDT screenings.

OmniCare

Member Outreach and Marketing Representatives/Specialists are aggressively contacting enrollees and providing care coordination services to facilitate access to care for OmniCare Health Plan (OCHP) enrollees. The enhanced outreach efforts encourage families to understand and participate in the program. OmniCare is currently working

with LeBonheur's Comprehensive School Health Program to increase visibility in the City School System to ensure referral information and assistance for screenings. OmniCare is currently working with Provider Services by having the Provider Service Representatives to manually collect claims from primary care providers to review to ensure accuracy of CPT coding of EPSDT services. Member Outreach has updated the EPSDT incentive flyer/posters in order to make them more effective for use in churches, schools, Head-Start centers and etc. The revisions will enable the materials to be used as EPSDT posters for enhanced visibility. Oral outreach methods now include face to face informing of EPSDT services by Outreach Specialists and providers, as well as public service announcements and community awareness campaigns.

Victory Health Plan (VHP)

Victory Health Plan (VHP) has expanded their tracking mechanism for each member under twenty-one (21) years of age and has generated individualized reports by diagnosis and treatment. The evidence of mass mailings has shown outreach to all enrollees and that outreach activities were consistent. VHP has implemented a tracking system to notify providers and members of EPSDT benefits. VHP has offered new monetary incentives to their members who receive their screens according to schedule.

John Deere

To improve oversight capabilities, John Deere has implemented a process to increase the sample size for EPSDT medical reviews. In a collaborative effort with other MCOs, John Deere is holding education health fairs for homeless shelter providers. Work has started to provide data to regional health offices about delinquent EPSDT children. John Deere continues to produce a large amount of marketing material in an effort to increase screening rates.

BlueCare

BlueCare has developed a practitioner database with consumers under the age of 21 to assist with EPSDT. BlueCare has generated a monthly list to identify members who are past due for EPSDT services. Also, the case management department is including scripted EPSDT screening evaluations when they contact consumers regarding the need to make an appointment for EPSDT services. BlueCare continues the use of many marketing strategies for outreach, i.e. health fairs, baby showers, brochures and new member conference/workshop. BlueCare has collaborated with health departments for member screenings.

Universal

Universal is developing an EPSDT tracking system. Evidence from joint Operations Committee meetings showed provider education activities to improve delivery of EPSDT services. Universal is implementing targeted PCP follow-up with letters identifying children behind in receiving EPSDT check-ups.

Better Health Plan

A systematic process for contacting members by telephone and mail has been effective in reaching more of the enrollee population. A process has been developed and implemented to assist members in making appointments and reminding providers of scheduled EPSDT appointments. Better Health Plan continues to use and expand the EPSDT tracking system to generate a report on individual enrollees that details benefit delivery. Better Health Plan's Medical Director and Director of Special Projects have developed extensive educational materials to assist providers in completing all elements of a complete EPSDT visit.

Preferred Health Partnership

Marketing flyers/brochures, member handbooks and other material on various topics including, but not limited to: well baby information, dental, vision and immunizations are mailed to members on an on-going basis. Non-English literature is also provided to PHP enrollees. PHP works collaboratively with other MCOs in EPSDT Outreach Health Fairs. An EPSDT tool has been developed for the Credentialing Quality Review Coordination to use when performing routine medical record reviews. This allows PHP to do continuous random "quick" audits of provider charts during routine reviews.

TennCare EPSDT Provider Video

The EPSDT provider video is an educational tool that shows the components of a screen and the CPT codes that a provider should use for billing. The video is approximately 16 minutes in length. Videos continue to be distributed to providers and health care organizations. Approximately 350 videos were distributed to providers attending the Tennessee Medical Association's Annual Workshop. Videos also continue to be distributed to the Managed Care Organizations, to health care advocacy groups, and to physicians' offices who are visited by the TennCare Quality Oversight staff.

PART II: HEALTH DEPARTMENT

A. Outreach and Screening Activities

EPSD&T screenings have now become a routine, regular component of all local health department clinics statewide. The service includes: assessment of each eligible child's need for a screening; education of the parent or guardian; outreach; and advocacy. These services have been institutionalized within the county health departments. Screenings are regularly offered to eligible children as they present for other health department services such as immunizations and WIC.

EPSDT Screenings by Health Department Regions
July 2002 through December 2002

	July	Aug	Sept	Oct	Nov	Dec	Total
Metropolitan regions:							
Davidson Co.	157	88	55	98	81	57	536
Hamilton Co.	350	248	206	208	215	149	1,376
Knox Co.	353	326	283	343	268	248	1,821
Madison Co.	117	84	55	83	38	23	400
Shelby Co.	658	1,062	523	490	399	688	3,820
Sullivan Co.	75	108	50	71	43	48	395
Rural regions:							
East Tennessee	317	528	389	343	220	195	1,992
Mid Cumberland	263	522	261	336	198	172	1,752
Northeast	580	748	452	429	350	249	2,808
South Central	393	467	339	287	205	217	1,908
Southeast	244	341	220	253	127	138	1,323
Upper Cumberland	540	558	369	281	212	173	2,133
West Tennessee	1,233	1,267	954	903	733	567	5,657
TOTALS	5,280	6,347	4,156	4,125	3,089	2,924	25,921

Outreach and advocacy activities continue to be an important service offered by the health departments. More emphasis is being been placed on referrals from other health department programs. With the need to reach a greater number of adolescents, EPSDT services have been linked closely with the Family Planning Program so that eligible adolescent girls in clinic for family planning are routinely offered EPSDT screening. The Children's Special Services (CSS) staff assure that children with special needs being provided CSS services are screened, by making referrals to Primary Care Physicians or in the local health departments.

The staff of programs providing home visits to infants and children provide education and assistance with scheduling appointments to the families they serve.

As reported in the July 2002 Semi-Annual Report, a refusal code has been implemented in the PTBMIS computer system used in all local and metropolitan health department clinics. For all children on TennCare, an assessment is always made while the child is present in clinic to determine if the child is due for an EPSDT screen according to the periodicity schedule. If due a screen and the child is present, the child will be offered a screen by the discipline that can do the screenings. If for any reason the screening cannot be done that day, an appointment will be scheduled for a later date, either with the local health department or with the primary care provider (PCP). If the parent or guardian refuses either to have the screen that day or make an appointment at a later date and the provider has made an effort to educate, encourage and assist the parent with getting the needed screen, then the refusal code is documented on the encounter form. During the six-month period of this report, 1,023 valid refusal codes were documented.

The East Tennessee Regior continues to meet quarterly with representatives of the MCO's serving the regions (Blue Care, PHP and John Deere). These meetings have greatly improved communication between the groups.

B. Health department success stories

The following stories are representative of those from all public health regions. (Names have been changed.)

- Timothy was seen at the health department for a routine EPSDT. An unusual sounding heart murmur resulted in referral to his PCP who diagnosed the child as having mitral valve prolapse. Timothy is now under the care of a cardiologist.

- Children are routinely referred to a PCP for previously undiagnosed conditions including: scoliosis, ear infections, vision problems, low hemoglobin, and abnormal urinalysis.

- Health department staff located PCPs for many children who did not have one.

- Maria was referred to her PCP for follow-up of hematuria and proteinuria in her urine specimen and failure to pass the hearing test. Maria was diagnosed with a seizure disorder and started on Dilantin.

- Ibrahim was determined to be at risk for tuberculosis and given the PPD skin test with positive results. Ibrahim's PCP placed him on TB medications.

Part III: Department of Children's Services (DCS)

A. Screening Activities

During the last six months, DCS has continued its efforts to ensure that youth in custody receive EPSDT screenings and that quality medical and mental health care is provided to our youth. To these ends, DCS has participated in responding to the Special Master's

requested itemized assessment protocol (IAP) and in developing a work plan derived from the needs identified in the IAP.

DCS continues to assure that children in custody receive their EPSDT screenings. According to TnKids data for October (the latest data available), 97% of children in DCS custody had been taken to their annual EPSDT examinations. In October, four regions had a completion rate of 98% or above: Shelby, Knox, Upper Cumberland, and South Central. For the three past months with data available, all 12 regions had individual completion rates greater than 92%. The percentage of children with EPSDT exams completed within the first 30 days of entering custody was 75.26%. The statewide percentage of children with dental exams was 87.18%.

B. DCS: Training Initiatives

Through our reform efforts, DCS undertakes yearly needs assessments. Last year's needs assessment emphasized the need for DCS staff to have a clear understanding of what it means to do their job well. The development of a practice model was undertaken to provide this definition and this document is currently in draft form.

The draft DCS practice model contains many issues concerning general child welfare practice, but includes specifically a chapter containing health care standards. A group of health care stakeholders made up of the plaintiffs attorneys, representatives from TennCare Consumer Advocacy, representatives from the Department of Health, representatives from TennCare, representatives from Tennessee Department of Health, representatives from Tennessee Commission on Children and Youth (TCCY), and representatives from the Center of Excellence were invited to review the material, give feedback privately and participate in a group discussion. Representatives from TennCare Consumer Advocacy, TennCare, Department of Health, Center of Excellence, and Department of Mental Health and Developmental Disabilities submitted feedback through written communication or through group discussion. TCCY has requested to remain involved in the process.

The practice model is currently going through revisions and will then be submitted for final approval to the DCS management team. Once approved, it will be the basis for renewed training efforts for field staff.

In addition to this major undertaking, DCS health unit staff continues to participate in foster parent training and case management training. DCS health unit conferences were held in September and December to bring to the field important information concerning TennCare's new waiver, adoption assistance, TennCare appeals, and re-verification.

DCS and Advocare participated in a joint training session at the Tennessee Association of Mental Health Organization's annual meeting. The session focused on how service levels in Advocare's system and DCS' system corresponded. The intent was to ease some of the difficulties in communication.

C. DCS: Information Resources

DCS has also been actively participating in the new TennCare Information System meetings to ensure that TennCare's system will be able to assist DCS with EPSDT data and health history information.

In addition DCS has begun designing changes to TnKids (DCS' information system) health care component. Approval for the project was received in November and meetings for the re-design have begun.

PART IV: UT Study of Children at Risk for State Custody

This is a two-part contract designed to develop an updated response to Paragraph 73 of the Consent Decree. Both parts are being conducted under contract with the UT Children's Mental Health Services Research Center (CMHSRC).

The first part involves a study with a sample from rural and urban East Tennessee Counties, while the second part includes a sample derived from Shelby County. The Shelby effort was scheduled to run approximately 3 months behind East Tennessee due to the development and start-up of the research infrastructure in Shelby County by CMHSRC. The two parts will be merged by the CMHSRC, resulting in a single combined study.

The study includes a sample of children believed to be at risk of state custody and their families who have been referred to juvenile and family courts. The study will describe the mental and behavioral health needs of children and families referred to juvenile and family courts in Tennessee and the adequacy of the behavioral and mental health services they receive. An important objective of the study is to determine whether behavioral and mental health services provided through TennCare and other sources to children at risk of state custody improve their mental health and reduce their risk of entering state custody. As a part of this effort, the study is designed to identify individual, family, and service factors that predict the improvements in children's mental health and placement in state custody.

The study has concluded baseline data collection on over 1200 children and their caregivers and is now collecting follow-up data on this sample. The study will be reported in three parts. Part I will describe the baseline data and retrospective portion of the study. Part I will include the demographical characteristics of the sample, the level of mental health and behavioral problems among the children in the sample, and the functioning of the children's caregivers and families. Part II will describe the follow-up data and prospective portion of the study, including the mental health services received by the children and families in the six-month period following the baseline interview and the effect of those services on reducing the risk of state custody. Parts I and II will be submitted together in a single report by March 31, 2003. Part III will use encounter data (which lags 3 months behind) provided by the Bureau of TennCare to describe the

specific behavioral and mental health services funded by TennCare that were provided to these children and families. It will be submitted as an addendum to the first report.

Part V: Division of Mental Retardation Services (DMRS) EPSDT Activities

While the Division of Mental Retardation Services does not provide any direct EPSD&T services, the division encourages each family whose child receives Home and Community Based waiver services to access screenings, diagnosis, and treatment through the child's PCP. DMRS staff has used the EPSDT outreach materials and video to familiarize Independent Support Coordinators for each child with the program so that they can work more closely with the PCP to access needed medically necessary treatment services. They have been given a list of the EPSDT coordinators for each MCO when they experience concerns or have questions. Children who are now entering the HCBS waiver are assigned to TennCare Select.

The Intake staff in each of the three regional offices has been informed about the EPSDT program. The staff tells families of Tenncare eligible children who are requesting services from the Division of Mental Retardation services about the EPSDT program and how to access those services. While children are waiting for DMRS services, the intake staff keeps families apprised of changes to TennCare and EPSDT.

Part VI: EPSDT Dental Activities

A. Public Health Department: Dental Screening Activities

In the spring of 2001 in an effort to improve access to dental services for low-income Tennessee children, the Bureau of Health Services of the Tennessee Department of Health (TDH) began a process to significantly expand its dental programs. Specifically, clinical dental services were enhanced through one-time special needs grants to counties for expansion and construction of dental clinics; preventive dental services were greatly expanded through a contract with TennCare which funds the School Based Dental Program; and services to remote areas without dental clinics were improved through the purchase of mobile dental clinics.

Dental special needs grants were awarded to 22 counties. These one-time funds were earmarked for renovation or upgrading existing dental facilities and for new dental construction. Projects have been completed in 12 of the 22 counties. They are: Cannon, Cocke, Cumberland, Hamilton, Hawkins, Lincoln, Monroe, Polk, Putnam, Rhea, Sumner, and Sevier. Those projects to be completed during the spring and fall of 2003 are Blount, Grundy, Hamblen, Lewis, Montgomery, Morgan, Shelby, and Washington. Jefferson and Loudon Counties have not taken any action at this time on their projects.

School based dental prevention services have begun in all regions except Madison County. Services are to begin there January, 2003.

Table 1 presents cumulative figures covering the six-month period from July 1, 2002 through December 31, 2002. During the first 6 months of the current fiscal year, the following services were provided:

- 50,919 **dental screenings** were conducted in 179 schools and 185 non-school sites;
- 15,586 children who exhibited obvious symptomatic or asymptomatic disease were **referred** for dental care; representing 31 percent of those screened.
- 18,147 TennCare children received a **comprehensive oral evaluation** by a licensed dentist;
- 19,273 children at high risk for dental caries had **dental sealants** applied to 90,839 teeth for an average of almost 5 teeth sealed per child.
- 55,448 children received **oral health education** programs at their school, preschool, or non-school site by a public health dental hygienist.

TABLE 1. Preventive Dental Services Delivered July 1 Through December 31, 2002

Report Period: Jul-Dec (Month) 2 (Year) Region: Statewide

Program	Number of Schools	Number of Non-School Sites	Number of Teeth	Number of Recipients
Dental Screening				
1. General	179	185		50,919
2. Referred for Treatment				15,586
Periodic Oral Evaluations (D0120S)	150	138		18,147
Dental Sealants	154	54	90,839	19,273

Staffing for the school based dental prevention projects has continued to improve. Currently 78% of our 102 allotted positions are filled. This is up from 63% at this time last year.

Mobile dental clinics: In an effort to improve access to dental services for high risk children in under-served areas, the Bureau of Health Services of the Tennessee Department of Health purchased 3 mobile dental clinics last year. Two are in operation (Mid-Cumberland and Northeast) and a third is to be delivered to West Tennessee in May. These clinics offer comprehensive dental services to children at school sites. From July through December 2002 the following services have been provided:

- 683 patient visits
- 2188 dental procedures performed at a dollar value of $92,927.

Data Management: July 1, 2002 all regions began to submit data electronically. All regions have received and are using their laptop computers to enter data onsite. As all sites began to use the Access program several problems with the program were detected and corrected. Despite training and revisions to the software program, several regions are experiencing difficulties in entering and transmitting data. During January and February 2003, the Bureau of Health Services of the Tennessee Department of Health will be offering onsite training to bring these programs up to speed. Discussions are under way with TennCare to share information concerning TennCare children obtained through our school based dental prevention project. At this time, only aggregate numbers of children treated are reported to TennCare. Once the Access data is compiled and edited, the Bureau of Health Services of the Tennessee Department of Health can report services provided to TennCare enrollees by individual child.

B. TennCare: Dental Carve-out

On October 1, 2002 implementation of the TennCare Dental Carve-Out began. Dental services are now being provided statewide through one Dental Benefits Manager contracted with the state on an administrative services basis. Doral Dental of Tennessee was awarded the contract based on a procurement process and bid evaluation.

Doral Dental of Tennessee is a subsidiary of Doral Dental USA, the largest administrator of dental services for Medicaid programs in the country. Doral has similar statewide contracts with Illinois and Kansas and had subcontracted with 6 of 10 TennCare MCOs in the 5 years preceding the carve-out.

The state implemented the carve-out in the hopes of improving access to covered services and to increase the level of compliance with the EPSDT Consent Decree. Pursuant to the contract Doral must maintain an adequate dental provider network, process and pay claims, provide member and outreach services, as well as achieve certain benchmarks or performance objectives spelled out in the contract. Services under the contract extend for 3 years. The state plans to make this an "at-risk" contract after the initial 3-year contract period is up.

Having a single dental administrator has made the TennCare program much more attractive and convenient for dentists. Dentists sign one provider agreement, they are credentialed once, and they operate with one maximum allowable fee schedule.

In an effort to increase access and utilization of the dental program, particularly by EPSDT children, the reimbursement level for dentists was increased. Participating dentists are reimbursed at the lesser of billed charges or the 75th percentile of the fees published by the American Dental Association (ADA) for the East South Central (ESC) region in 1999.

On September 23, one week before the dental carve-out, the dental network consisted of a total of 386 individual dentists to treat over 629,000 TennCare children. By January 21, there were 618 individual credentialed dentists to treat almost 656,000 TennCare children. This represents over a 60 percent increase in the dental provider network in the first 4 months of the program.

Information based on paid claims data derived from Doral's Business Intelligence System (DBIS), revealed that at least 85,930 TennCare enrollees under age 21 received dental treatment from October 1 through December 31, 2002. Because of a claims lag this is an understatement of the actual number of unduplicated children enrollees who visited the dentist.

Presentations, journal articles, newsletters, and press releases by the American Dental Association, the Tennessee Dental Association, the Pan Tennessee Dental Association, and the Bureau of TennCare have been effective in promoting the carve-out and in encouraging dentists in Tennessee to participate in the program.

The TennCare Dental Advisory Committee, formerly known as the Children's Oral Health Planning Group, held its first official meeting on October 4, 2002 and has met on a monthly schedule thereafter. The next scheduled meeting is Friday, February 7, 2003. The Advisory Committee consists of 20 members who review and make recommendations to Doral and TennCare concerning the dental program. This group has offered assistance in the development of policies and ensures that information is communicated to dentists across the state through their newsletters. At the group's request, the Directors of the TennCare Program Integrity Unit and the TBI Medicaid Fraud Control Unit have met with the committee to explain how best to monitor utilization and service delivery to prevent fraud or abuse in the dental program.

Besides working with Doral Dental, organized dentistry and the private dental sector in the financing and delivery of dental care, the TennCare Bureau is also working closely with the Department of Health's Oral Health Services section to provide statewide oral disease prevention. It is anticipated that over time these partnerships will result in measurable improvements in children's oral health in Tennessee.

Part VII: Implementation Team Activities

As noted in the July 2002 semi-annual report, the Implementation Team (IT) has continued to received complex case referrals but the number of children entering custody after referral has continued to decline.

The IT has been successful in assisting with facilitation of services by serving as liaison between individuals and entities that might include BHO, family, advocates, schools, or state agencies. The reasons for custody on the referred cases were child welfare and juvenile justice oriented issues. Although there is no historical comparison data with which to compare children's rate of entering custody before and after the start of the Implementation Team, there has been substantial change in the numbers of referred cases that enter custody in the two years of the Implementation Team operation. These changes are as follows:

- 20% entered custody between 6/00 and 6/01
- 13% entered custody between 6/01 and 6/02
- 7 ½ % entered custody for the entire 2002 year
- 6% entered custody between 7/01 and 12/31/02

The Implementation Team received 92 referrals between 7/01 and 12/31 and a total of 191 case referrals on 173 children for entire year of 2002. 18 children referred in 2002 were already in custody at time of referral and 13 children came into custody after referral. However, the Implementation Team was able to facilitate the release of 6 children from custody in 2002. In addition, the Implementation Team had 6 cases, 5 of them complex dually diagnosed MR/MH/DD children, that were carried over from 2001.

Part VIII: Centers of Excellence

The primary activity of the COE is to provide assessment/diagnostic, consultation and referral services for children in or at risk of state custody. A significant aspect of these services is the triage of phone calls to determine if the referral constitutes a need for additional diagnostic/assessment services.

Operation of the Centers of Excellence (COEs) began in January with execution of the first COE contract with Vanderbilt University. This COE is fully staffed, but as utilization patterns emerge, there appears to be a need to re-configure the staff to offer more psychological and social work services, and less psychiatric coverage. Since its inception the Vanderbilt COE has seen a total of 187 children, including 113 between July 1, 2002 and December 31, 2002. The COE has also triaged 182 calls, including 93 for July through December, and 130 cases were considered in Case Review.

The second COE, the Boling Center at the University of Tennessee in Memphis, became operational on March 4, 2002. This COE is now fully staffed. During the reporting period of July 1, 2002 through December 31, 2002 the COE at UT Boling received 108 triage calls. From March 15 through December 31, 2002, the number of children seen for face-to-face contacts was 61; this includes 36 children who were seen during the period between 7/1/02 and 12/31/02. Face-to-face contacts usually involve multiple consultations with a multi-disciplinary team. The COE at Boling has completed 61 Care Plans for the children who have been seen face-to-face since the inception of this COE. In addition this COE has written 82 Care Plans (52 from 7/10/02) that were based upon record reviews, conversations with case mangers and treatment providers, and team staffings.

The contract with East Tennessee State University was executed, and this COE began operation on August 1, 2002. By late October this COE was almost fully staffed with the hiring of a social worker and child psychologist, in addition to an office manager and two child and adolescent psychiatrists. Efforts to recruit a pediatrician continue. While ETSU received 10 triage calls from August 1 through December 31, 2002, staff completed two brief consults, 29 staffings, 6 psychiatric evaluations, one psychological assessment and six medical management visits.

The Chattanooga COE at T. C. Thompson Children's Hospital and a fifth COE, a collaboration of the East Tennessee Children's Hospital and Cherokee Health Systems, remain in the contract development/proposal stage.

Another function of the COEs is to provide consultation via training to DCS and CSA staff. Topics include basic interviewing skills, a review of common and complex diagnostic categories and behavioral disorders, referrals and accessing services,

During the last half of 2002, the Boling/UT COE presented 22 hours of training. In the year 2002, the COE at Vanderbilt spent 136 hours on training activities. The COE at ETSU presented to 180 DCS staff members during August 2002, and has distributed a needs assessment survey for training to DCS offices. ETSU plans to initiate a Best Practice Network (BPN) training with a meeting in January, 2003, and to offer training of cognitive behavioral methods and use of a level of care utilization assessment tool.

The COEs also have responsibility for recording any service denials by the MCOs or BHOs which involve children for whom they provide services, for reporting on any disputes between the MCOs and BHOs related to COE cases, for reporting on the adequacy of MCO and BHO networks, and for reporting on coordination problems in the health care system as a whole as they affect children in custody or at risk of custody. The operational COEs have provided detailed reports and have provided observations of the health care system based upon the children they have assessed, provided consultations for, or otherwise served.

The COEs have maintained regular schedules of on-site consultations and review of cases with each DCS region within their catchment area. DCS administrators and field staff have been very enthusiastic about the services provided by the COEs and have been making appropriate use of the expertise of the COEs. COE leaders have commented on the complex needs that these children exhibit.

The current data reporting system for COEs is under review. The format of reporting data in the quarterly reports will be revised to include more detailed information and a more standardized means of reporting data across COEs.

Two quarterly meeting of the COEs were held: on August 14, 2002, and again on November 13, 2002. All five COEs were well represented. The Vanderbilt, ETSU and UT Boling Center COEs provided information on start-up of services, the complexity of cases they have encountered, the good reception they have had from DCS, and the strengths and weaknesses of the health care system they have observed in working with children with complex needs.

Part IX: EPSDT Monitoring Activities

A. TennCare: Provider network reviews

The Provider Network Compliance unit of TennCare performs a wide range of quarterly and ad-hoc GeoAccess analyses. During these analyses, a specific analysis is performed utilizing EPSDT providers. The Managed Care Organization must report a provider as actively providing predetermined EPSDT and PCP functions in order for that provider to be included as a participating EPSDT provider in the GeoAccess analysis. The "TennCare Provider Enrollment File" contains a data field that must be populated

with "yes" or "no" to indicate this provider is providing EPSDT services. This ensures that no provider can be included in any analysis as a provider of EPSDT services unless the Managed Care Organization has reported this information on the "TennCare Provider Enrollment File". These reports provide a view of the availability and accessibility to an EPSDT provider. Each eligible TennCare enrollee under age 21 should have access to an EPSDT provider as outlined under Primary Care in the "Terms and Conditions for Access" section of the TennCare waiver.

Other analyses are performed to ensure EPSDT procedures may be available even though a provider may not be specifically flagged as providing EPSDT services. These analyses are Pediatric Providers, Vision Providers, and General Dental Providers and are preformed quarterly as well. Currently, no deficiencies have been identified for EPSDT, Dental or Vision providers for any Managed Care Organization.

B. TennCare/Office of Contract Development and Compliance(OCDC)

The Office of Contract Development and Compliance (OCDC) submits the following EPSDT monitoring activities for the period of July to December 2002.

I. POLICIES AND PROCEDURES

During this period, OCDC developed ten (10) new policies and procedures to improve the monitoring and tracking of the Managed Care Corporations (MCCs) implementation of the Revised John B. Consent Decree.

II. QUARTERLY MCC EPSDT COORDINATORS MEETING ISSUES

The Bureau of TennCare held a quarterly meeting of all EPSDT Coordinators on October 7, 2002. A discussion arose about what questions EPSDT enrollees were being asked by the transportation subcontractors when requesting transportation services. OCDC requested each MCC's transportation subcontractors' script for review and analysis. Particular attention was given regarding questions used to determine if an enrollee had any special needs or transportation assistance issues (wheelchair; stretcher; etc.); the need for travel, meals or lodging expenses; or if an attendant was needed to accompany the enrollee. OCDC is currently (January 2003) involved in the process of reviewing each MCCs subcontractor's script and anticipates completion of this task to include feedback to each MCC targeted for February 15, 2003.

III. MEMBER HANDBOOKS AND ADDITIONAL MARKETING MATERIALS

Member handbooks for distribution to EPSDT enrollees are reviewed on an annual basis for EPSDT compliance by the Marketing Section of OCDC. See

Attachment titled "Office of Contract Development and Compliance, EPSDT Semi-Annual Report, July to December 2002", Attachment A. During the reporting period, the MCCs submitted revised member handbooks and additional marketing materials for review and approval by the Marketing Coordinator and were found to be in compliance.

IV. QUARTERLY UP-TO-DATE LISTS OF SPECIALISTS

Per Paragraph 62. of the Revised John B. Consent Decree, each MCC is required to provide each primary care provider participating in the EPSDT program an up-to-date list of specialists to whom referrals may be made for screens, laboratory tests, further diagnostic services and corrective treatment.

During this period, all MCCs submitted proof of documentation to TennCare of the updated list of specialists along with proof of timely mailing with the exception of Universal Care of Tennessee.

V. PROVIDER MANUAL REVIEW

Per Paragraph 75. of the Revised John B. Consent Decree, TennCare shall prohibit MCOs from imposing blanket restrictions or requirements on transportation to EPSDT enrollee's because of their age or lack of parental accompaniment.

Per Paragraph 76. of the Revised John B. Consent Decree, TennCare or their Contractors shall provide non-emergency transportation in accordance with 42 U.S.C. Section 1396d(a)(25); 42 C.F.R. Section 440.170(a), 441.62; State Medicaid Manual Section 5150. Transportation assistance includes "related travel expenses," cost of meals and lodging in route to and from care and the cost of an attendant to accompany a child if necessary.

During this reporting period, OCDC reviewed a revision (June 2002 edition) to the Provider Manual submitted by Tennessee Behavioral Health. OCDC requested Tennessee Behavioral Health revise the transportation section (Chapter 8) and to re-submit the manual to OCDC for final review and approval.

VI. EPSDT POLICY TOOL FOR TENNCARE MANAGED CARE ORGANIZATIONS

OCDC recently received the 2003-draft proposal of the EPSDT Policy Tool for TennCare Managed Care Organizations prepared by the Quality Oversight Division of the Bureau of TennCare. Currently the proposal is being reviewed by OCDC to ascertain if all requirements are being met. Target date for review completion by OCDC is February 15, 2003.

VII. EPSDT TRANSPORTATION REVIEW CHECKLIST

During late fall 2002, OCDC developed an EPSDT Transportation Review Checklist of the EPSDT transportation requirements pursuant to 42 U.S.C. Sections 1396a (a)(43),1396d(a) and (r) and 42 CFR Part 441, Subpart B. See "Attachment titled, "Office of Contract Development and Compliance, EPSDT Semi-Annual Report, July to December 2002", Attachment B. The checklist is intended to be a guide to assist OCDC staff when they are reviewing MCC Member Handbooks, Provider Manuals, EPSDT Marketing Materials, Transportation Policies and Procedures and Transportation Vendor Subcontracts to ensure they contain the required language for compliance with EPSDT.

VIII. REVISION OF THE EPSDT TRANSPORTATION ASSISTANCE PROVISION

OCDC recently revised the EPSDT Transportation Assistance provision and continues to work with the Office of General Counsel (OGC) – Bureau of TennCare, the State of Tennessee Attorney General's Office and the Department of Health and Human Services Centers for Medicare and Medicaid Services to obtain approval of the revised policy.

LIQUIDATED DAMAGES ASSESSED

Per Paragraph 101. of the Revised John B. Consent Decree, TennCare will review appeals filed under the TennCare Program to determine whether deficiencies or repeated violations necessitate financial penalties upon managed care contractors, which have inappropriately denied EPSDT services to children.

During this period, liquidated damages were assessed for EPSDT enrollee cases. It is important to note that only one sanction was assessed which reflects better compliance on behalf of the MCCs. The enrollees are receiving the services for which they appealed.

Part X: Department of Mental Health and Developmental Disabilities Monitoring

A. BHO Monitoring

In addition to EPSDT screening for youth in DCS custody done through TennCare Select by DCS, the BHOs perform evaluations and offer services to those children with potential mental health needs. The attached report, "Monitoring of BHO Provided Services for DCS Children, October 2002," describes the services provided to children and adolescents in DCS custody between July 1, 2000 and March 31, 2002. See

Attached report, "Monitoring of BHO Provided Services for DCS Children, October 2002". Note that the report does not necessarily represent services received in a DCS Level 3 or Level 4 facility, much of which is administered directly by DCS. As described in the report, of the 12,813 children in DCS custody between October 1, 2001 and March 31, 2002, 62% of the children assessed as SED received one or more mental health screens and 26% of the non-priority children received assessments. In addition, 33% of the children in custody during that period received some form of mental health case management service. These percentages are expected to increase over time as the BHO and DCS work to ensure that all priority children in DCS custody are offered mental health case management.

B. Mental Health: TennCare Partners Quality Assurance

TennCare has a contract with the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) which gives TDMHDD responsibility for certain aspects of monitoring of the quality of mental health and substance abuse services offered through the TennCare Partners Program. Oversight for the program consists of the following:

- Review of access and quality of care standards;
- Use of established mental health service indicators and monitors;
- Monthly review of provider networks;
- Yearly consumer and provider satisfaction surveys; and
- Monthly review of appeals and directives

BHO access and quality of care standards are contractually prescribed. Each of the BHOs has its own Quality Monitoring Plan (QMP), which is written into the contract between that BHO and TDMHDD. Oversight of the established standards is monitored on an on-going basis by the TDMHDD Office of Managed Care, by the TDMHDD Office of the Medical Director, who monitors the best practice guidelines and by the Bureau of TennCare's Quality Oversight Unit, which is responsible for overall monitoring of EPSDT and case management services.

C. Review of Access and Quality of Care Standards

The July 2002 *Best Practice Guidelines: Behavioral Health Services for Children and Adolescents* details the current standards and practices recommended by the TDMHDD Office of the Medical Director. See Attachment titled, "Best Practice Guidelines, Behavioral Health Services For Children and Adolescents, Department of Mental Health and Developmental Disabilities, July 2002".

Every quarter, the TDMHDD Office of Managed Care delivers a report on service utilization and monitoring of the BHOs to the Bureau of TennCare. The children and adolescent sections of the Progress Report for FY2002 includes demographic information on TennCare eligibles (such as race, age group and regional dispersion) and detailed service utilization for the child and adolescent population served by TennCare Partners, both priority (SED and SPMI) and non-priority. See Attachment titled, "Progress Report on the TennCare Partners Program: Children and Youth, Fiscal Year 2002"). In addition, it includes a trend analysis of rates of TennCare Partners services for children and adolescents from July 1999 through July 2002, with projections for FY2003. As can be seen from both the rate for total children served and that for the

SED priority population, TennCare Partners continues to increase service to children and adolescents with mental health needs. Note, too, that these rates reflect only those services received through the Partners Program and not any additional mental health services received through TennCare MCO medical providers. In other words, the total rate of mental-health related service through TennCare for children and adolescents is most likely understated in these charts.

D. Monthly review of provider networks

TDMHDD monitors the BHO provider network monthly to ensure that the provider networks comply with the contractually mandated geographic standards. Network access is trended over time, and any changes or potential problems with access are discussed with the TennCare Bureau and the BHOs. The "Children and Youth Provider Network, October-December 2002" Attachment includes geoaccess maps showing the location of the BHOs' contracted providers for mental health services for children and adolescents and the areas of the state in which those providers may not be accessible. Please note that, although several maps appear to show areas of deficiency, those areas, all of which are in outlying counties with very low service utilization, have been determined to be acceptably covered by the BHOs per community standards on distance and by agreed upon contingency and/or substitute providers.

E. Yearly Consumer and Provider Satisfaction Surveys

The BHOs conducted both of the above surveys in late 2002. We expect the results of the Consumer Satisfaction Survey to be available no later than March 1, 2003, and the results of the Provider Satisfaction Survey to be available no later than April 1, 2003.

F. Monthly Review of Appeals and Directives

The Office of Managed Care has developed a system to monitor appeals and directives related to services provided by the BHOs and DCS, through which we hope to be able to identify and trend systemic issues. Beginning in February 2003, the Office of Managed Care will distribute a monthly report outlining the trends and identifying any recurring problems. The report will be distributed to the appropriate individuals at TDMHDD and the Bureau of TennCare. Note that this report is meant to be a supplement to the work already done by Schaller-Anderson of Tennessee on monitoring appeals and directives, details for which can be found in Part XII of this document.

Part XI: TennCare EPSDT Coordination Activities

A. The Children's Health Initiative(CHI)

The Children's Health Initiative ended on December 31, 2002. For a full report of the activities of the Children's Health Initiative, See Attachment titled, "Tennessee Caring for Kids, A Report from the Children's Health Initiative, 2002".

B. TennCare EPSDT workgroup

This group, which is chaired by Dr. Conrad Shackleford, continues to meet regularly to serve as a forum for exchange of EPSDT information among MCOs, as well as TennCare, the Department of Health, the Children's Health Initiative, and TNAAP, the EQRO, DHS, DCS, and the BHO. Representatives from the various managed care companies are afforded the opportunity to share EPSDT outreach strategies. The meetings also provide a forum to discuss common issues and to learn new/updated information.

Recent meetings have included an in-depth review of EPSDT coding, the seven (7) components of an EPSDT screening, and chlamydia screenings for females. Other meetings have focused on educational campaigns for EPSDT outreach.

C. Tennessee Academy of American Pediatrics(TNAAP)

For a full report on the activities of the Tennessee Academy of American Pediatrics, pursuant to its contract with TennCare, See Attachment titled, "Tennessee Chapter of the American Academy of Pediatrics (TNAAP), John B. Progress Report, August 1, 2002 to January 31, 2003".

Part XII: TennCare Solutions Unit: Semiannual Review of Appeals

The TennCare Solutions Unit (TSU) is the appeal resolution unit for TennCare. During the six months covered by this report, the unit has continued to undergo significant positive changes. These changes are intended to create better efficiencies, produce more informative data and better support the unit in its medical decisions regarding appeals. The enhanced file tracking system has enabled the TSU to locate files more efficiently regardless of whether the file is open or closed.

TSU works closely with Schaller-Anderson of Tennessee, Inc. (SAT), the contractor responsible for assisting with all medical appeals, and with internal units such as the

Office of General Counsel and the Office of Contract Development and Compliance in carrying out its activities.

A. TSU-identified EPSDT issues

The following issues are the major EPSDT issues identified by the TSU during this six-month period.

1. **Implementation of Dental Carve-out**: TennCare implemented a dental carve-out effective October 1, 2002. To better process dental appeals, the TSU has identified one individual as the primary responsible person to identify trends and systemic issues for these appeals. The TSU, in conjunction with Schaller Anderson Medical professionals and the TennCare Dental Director, have worked very closely with this new contractor to educate on the appeals process and the quality of the response to the enrollee.

2. **Disproportionate number of pharmacy appeals related to two drugs:** Zyrtec and Claritin products. These two items continued to account for over 50% of all EPSDT pharmacy appeals. SAT medical and pharmacy staff have shared information on the top 10 pharmacy medications appealed for children with the Tennessee Pharmacy Association as well as with all of the plans in an attempt to address changes to the formulary and prior authorization process where needed. The overwhelming percentage of the top ten medications appealed for (for children), continues to be for medication to address respiratory ailments.

3. **Better coordination for children in state custody: The** TSU has instituted processes to strengthen the relationship between the TSU and the advocacy group for children in state custody. The two groups, along with a DCS representative are now holding regularly scheduled meetings to discuss individual appealed cases and their resolution. In addition, Schaller-Anderson medical staff conducted training for the TSU on the different levels of placement and terminology used by both the BHO and DCS staff to enable better resolution of appeals.

B. Summary of reports

The Schaller-Anderson reports attached provide data on EPSDT related appeals activity during the second six months of 2002 and are specific to type of appeal, appeal totals per plan and in the aggregate.

1. **Overall EPSDT Appeals by Month**
   Details the number of appeals in the aggregate for each of the 6 months.

2. **EPSDT Area of Appeals**
   Details the types of appeals by volume. Pharmacy represents the largest type of appeal as is also true for adults. ProLaw has identified MCO Change Appeals as the second largest type followed by reimbursement and billing appeals. Pharmacy, MCC Change and Reimbursement and Billing appeals represent 92% of all appeals received. This is virtually the same percentage as the first half of the year. DCS and the BHO received less than 2% of all appeals respectively.

An analysis of the BHO and DCS appeals reveal that the majority of the BHO appeals for children are being filed as expedited (212 expedited as opposed to only 36 standard) while the DCS appeals are evenly split between expedited and standard (155 expedited and 254 standard). A further review of the appeals identifies the greatest number of BHO appeals were for residential treatment (84), and outpatient access (85) representing 169 of the total 248 appeals or 68%. A review of the DCS appeals identifies the greatest number of appeals were for Residential treatment levels (level 2 = 60, level 3 = 35, step down = 19) or 36.8%.

3. **EPSDT appeals per 1,000 TennCare Enrollees by MCO**
Details the number of appeals by plan per 1,000 enrollees for each of the six months. Universal Healthcare continued to represent a disproportionate number of appeals both for medical and pharmacy services as well as for MCO change appeals. All of the East Tennessee plans experienced higher than normal numbers of appeals, primarily due to the block transfers of TennCare Select enrollees to these plans.

4. **Top 10 EPSDT Medications**
Details the number of appeals by drug (in the aggregate). The majority of the top 10 drugs appealed for are for allergy/respiratory related diagnoses. This report has been shared with all TennCare plans, and SAT continues to work with them in an attempt to address modifications to their formularies and/or prior authorization processes. Zyrtec and Claritin products represent more than 50% of all EPSD&T related pharmacy appeals.

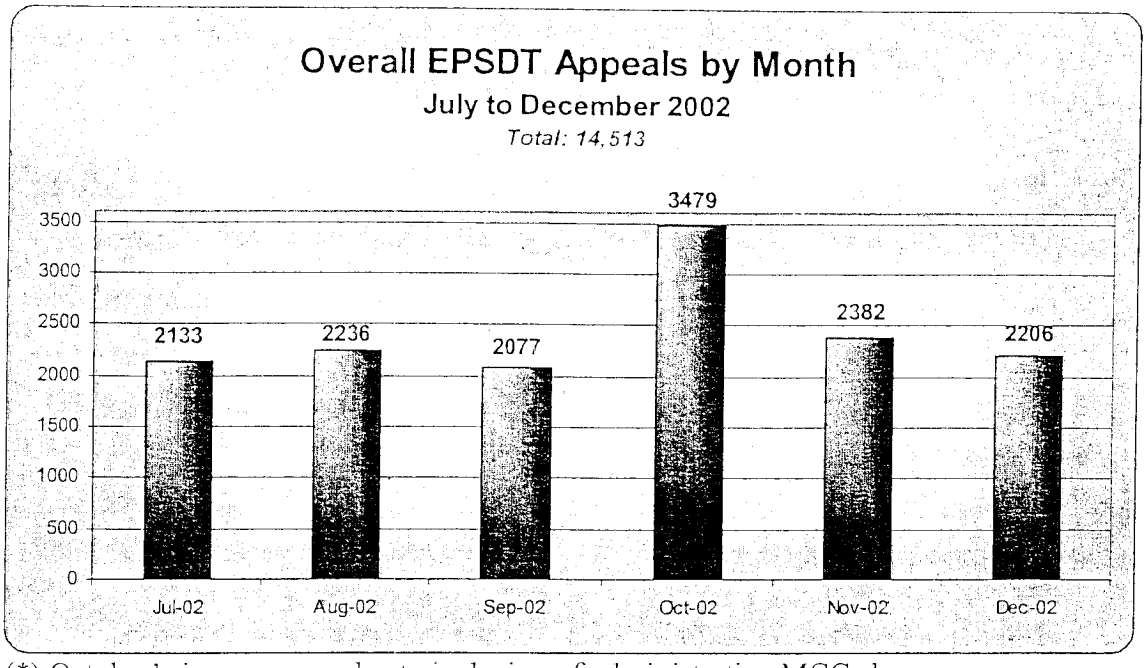
5. **EPSDT Enrollment by MCO by Region**
Details the age under 21 (EPSDT) enrollment percentages for each plan across the state (not appeals). As is expected, the plans with the highest overall enrollment also had the highest percentage of children (BlueCare and TennCare Select).

6. **EPSD&T Appeal types**
Details numbers of EPSDT appeals segregated by type; Pharmacy, Standard and Expedited. The designation of expedited is determined by the enrollee and is continuing to rise. The percentage of expedited appeals represented 41.7% of all non-pharmacy appeals.

7. **EPSDT Appeals per 1,000 by Month by Region**
Details the number of appeals by region of the state. The report is also laid out so that the grand regions of the state are grouped together from West to East. This chart further verifies the increase in appeals caused by requests for MCO change in both East Tennessee following the block transfers, and in middle Tennessee as a result of the continued problems with Universal.

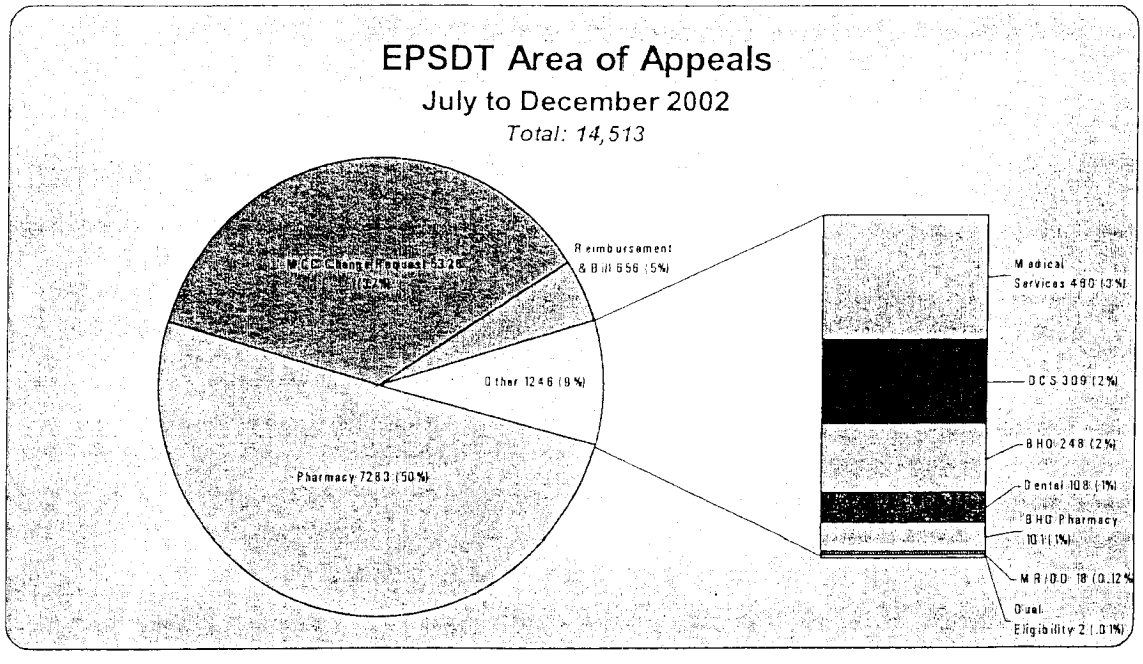
EPSDT Semi-Annual Appeals –July to December 2002

Chart 1.



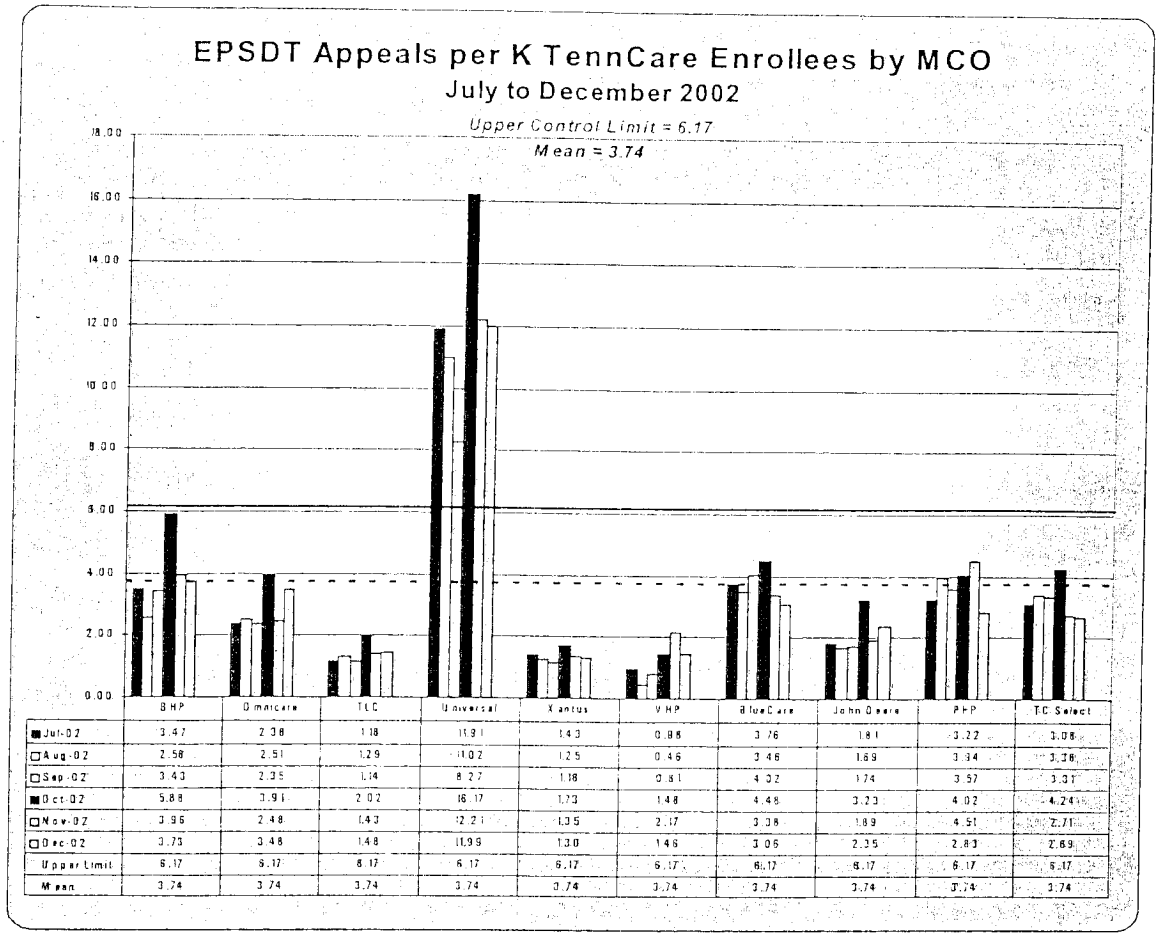
(*) October's increase was due to inclusion of administrative MCC changes

Chart 2.



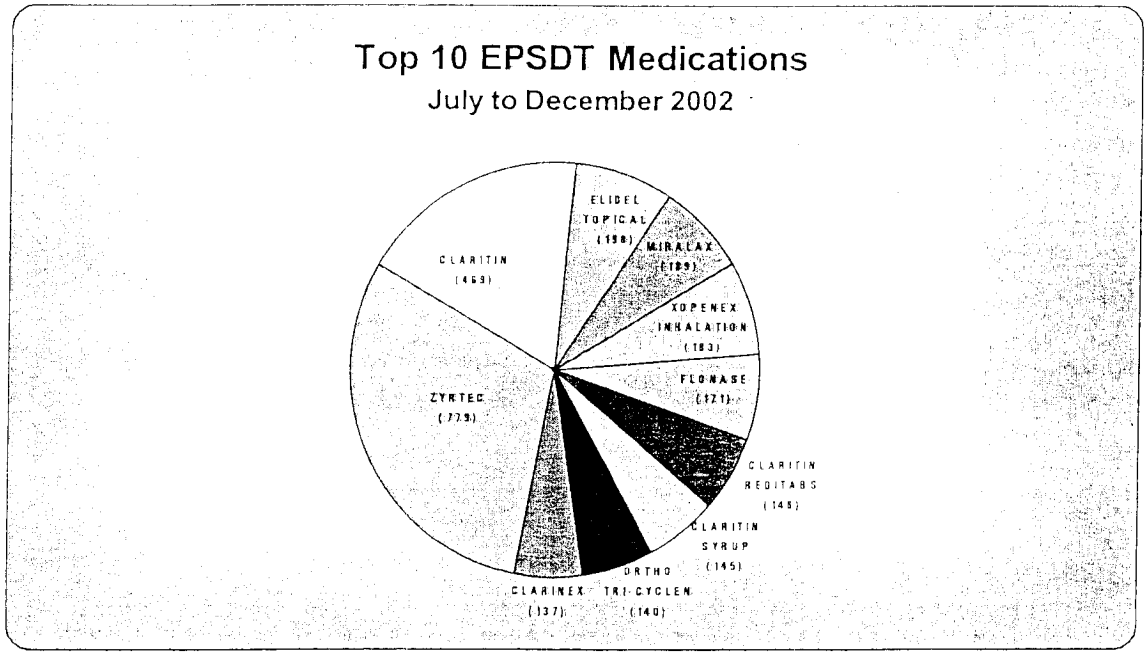
Source of data: ProLaw. Run date 1/6/03
Figures are subject to change due to a lag time in data entry.

Chart 3.



	BHP	Omnicare	TLC	Universal	Xantus	VHP	BlueCare	John Deere	PHP	TC Select
Jul-02	3.47	2.38	1.18	11.91	1.43	0.86	3.76	1.81	3.22	3.08
Aug-02	2.58	2.51	1.29	11.02	1.25	0.46	3.46	1.69	3.34	3.38
Sep-02	3.43	2.35	1.14	8.27	1.18	0.61	4.02	1.74	3.57	3.31
Oct-02	5.88	3.91	2.02	16.17	1.73	1.48	4.48	3.23	4.02	4.24
Nov-02	3.95	2.48	1.43	12.21	1.35	2.17	3.38	1.89	4.51	2.71
Dec-02	3.73	3.48	1.48	11.99	1.30	1.46	3.06	2.35	2.83	2.69
Upper Limit	6.17	6.17	6.17	6.17	6.17	6.17	6.17	6.17	6.17	6.17
Mean	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74

Chart 4.



Source of data: ProLaw. Run date 1/6/03
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Chart 5.

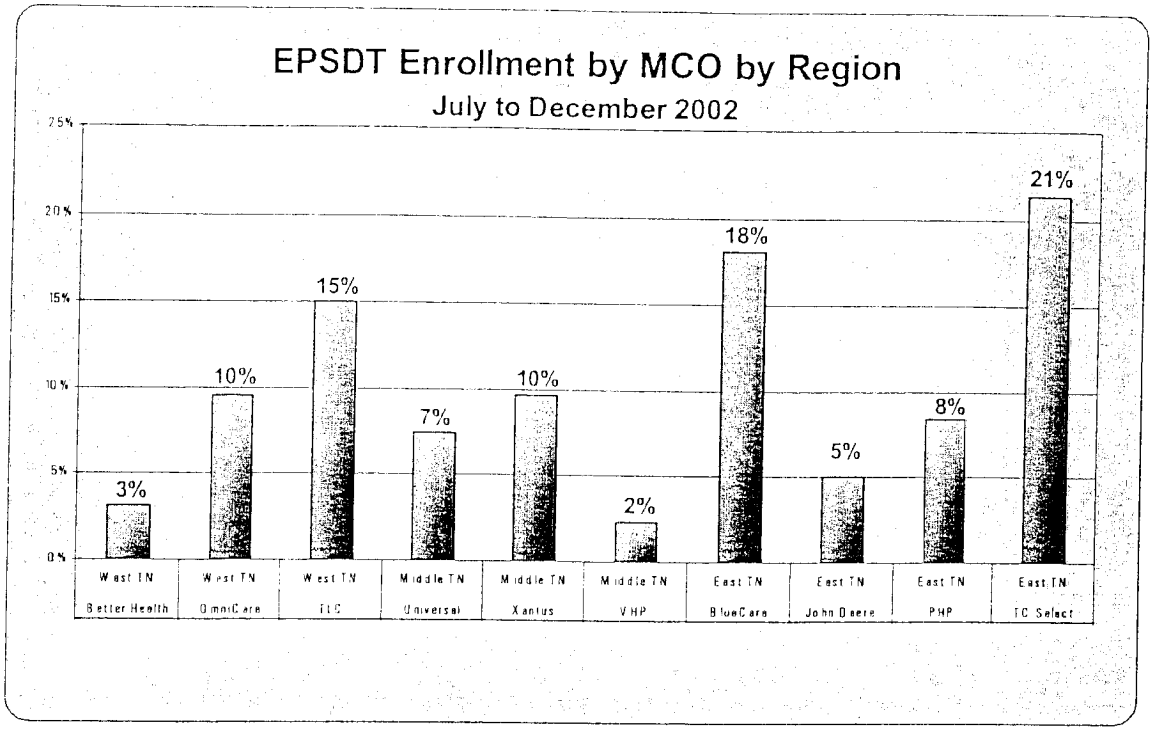
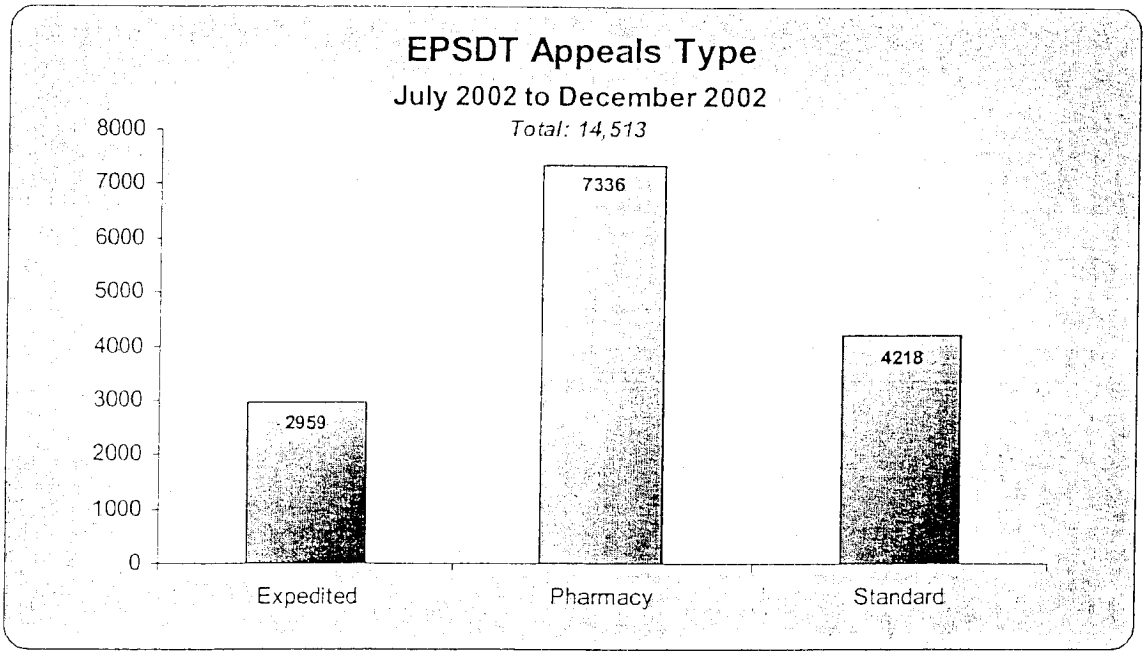


Chart 6.



Source of data: ProLaw. Run date 1/6/03
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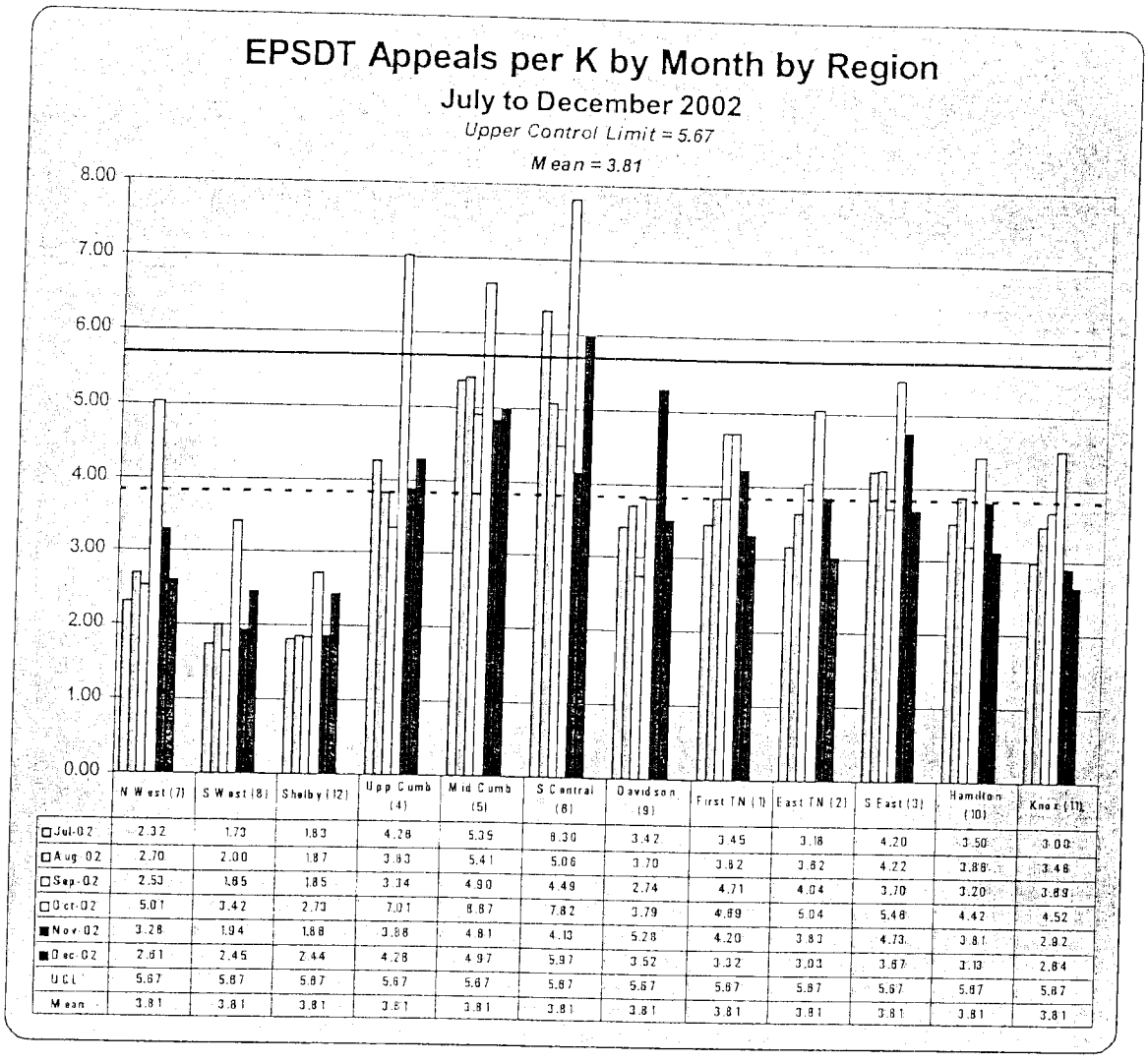
Chart 7.



	N West (7)	S West (8)	Shelby (12)	Upp Cumb (4)	Mid Cumb (5)	S Central (6)	Davidson (9)	First TN (1)	East TN (2)	S East (3)	Hamilton (10)	Knox (11)
Jul-02	2.32	1.73	1.83	4.28	5.35	8.30	3.42	3.45	3.18	4.20	3.50	3.00
Aug-02	2.70	2.00	1.87	3.83	5.41	5.06	3.70	3.82	3.82	4.22	3.88	3.46
Sep-02	2.53	1.85	1.85	3.14	4.90	4.49	2.74	4.71	4.04	3.70	3.20	3.89
Oct-02	5.01	3.42	2.73	7.01	6.87	7.82	3.79	4.89	5.04	5.48	4.42	4.52
Nov-02	3.28	1.94	1.88	3.88	4.81	4.13	5.28	4.20	3.83	4.73	3.81	2.92
Dec-02	2.61	2.45	2.44	4.28	4.97	5.97	3.52	3.32	3.03	3.67	3.13	2.84
UCL	5.67	5.67	5.67	5.67	5.67	5.67	5.67	5.67	5.67	5.67	5.67	5.67
Mean	3.81	3.81	3.81	3.81	3.81	3.81	3.81	3.81	3.81	3.81	3.81	3.81

Source of data: ProLaw. Run date 1/6/03
Figures are subject to change due to a lag time in data entry.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

OFFICE OF CONTRACT DEVELOPMENT AND COMPLIANCE

EPSDT SEMI-ANNUAL REPORT

JULY TO DECEMBER 2002

ATTACHMENT A.

Member Handbooks- Medicaid and Standard
Reviewed by: Jena Napier, Marketing Coordinator
For EPSDT- July 01, 2002 to December 31, 2002
Office of Contract Development and Compliance

MCO Name	Document	Date Received	Date Approved	Revisions
Better Health	Medicaid Member Handbook	11/06/02	01/13/03	Yes
Better Health	Standard Member Handbook	11/06/02	01/13/03	Yes
BlueCare	Medicaid Member Handbook	10/01/02	12/09/02	Yes
BlueCare	Standard Member Handbook	10/01/02	12/09/02	Yes
Doral Dental	Medicaid Member Handbook	08/07/02	09/27/02	Yes
Doral Dental	Standard Member Handbook	11/08/02	12/03/02	Yes
John Deere	Medicaid Member Handbook	11/04/02	12/13/02	Yes
John Deere	Standard Member Handbook	11/12/02	12/13/02	Yes
OmniCare	Medicaid Member Handbook	10/04/02	12/13/02	Yes
OmniCare	Standard Member Handbook	10/04/02	12/13/02	Yes
PHP	Medicaid Member Handbook	09/17/02	01/13/03	Yes
PHP	Standard Member Handbook	09/17/02	01/22/03	Yes
TennCare Select	Medicaid Member Handbook	11/20/02	12/13/02	Yes
TennCare Select	Standard Member Handbook	11/20/02	12/13/02	Yes
TLC	Medicaid Member Handbook	10/24/02	*****	Yes
TLC	Standard Member Handbook	10/24/02	*****	Yes
Universal Care	Medicaid Member Handbook	11/21/02	12/27/02	Yes
Universal Care	Standard Member Handbook	11/21/02	12/27/02	Yes
VHP	Medicaid Member Handbook	11/01/02	12/13/02	Yes
VHP	Standard Member Handbook	11/01/02	12/13/02	Yes
Xantus	Medicaid Member Handbook	11/12/02	01/07/03	Yes
Xantus	Standard Member Handbook	11/14/02	01/13/03	Yes

***** = Files are still outstanding and revisions have been requested.

The Bureau of TennCare requested each MCO to submit two handbooks due to the new wavier which became effective July 1, 2002. One handbook is a Medicaid Member Handbook and the other is a Standard Member Handbook.

Additional Marketing Materials on EPSDT
Reviewed by: Jena Napier, Marketing Coordinator
For EPSDT- July 01, 2002 to December 31, 2002
Office of Contract Development and Compliance

MCO Name	Document	Date Received	Date Approved	Revisions
Better Health	EPSDT Flyer	07/03/02	07/30/02	Yes
BlueCare	EPSDT- "Keep Your Child Healthy" Brochure	10/17/02	11/01/02	No
BlueCare	EPSDT- "Did You Forget?" Postcard	10/23/02	11/06/02	No
BlueCare	EPSDT- Envelopes	11/05/02	11/20/02	No
BlueCare	EPSDT- Poster Contest	06/21/02	07/08/02	No
John Deere	EPSDT- Postcard	10/22/02	11/12/02	Yes
OmniCare	EPSDT- Letter and Form	08/14/02	09/09/02	Yes
TennCare Select	EPSDT- "Keep Your Child Healthy" Brochure	10/17/02	11/01/02	No
TennCare Select	EPSDT- "Did You Forget?" Postcard	10/23/02	11/06/02	No
TennCare Select	EPSDT Envelopes	11/05/02	11/20/02	No
TennCare Select	EPSDT- Poster Contest	06/21/02	07/08/02	No
TLC	EPSDT- Poster	08/05/02	08/28/02	Yes
TLC	EPSDT- Past Due Preventive Service Visits	09/30/02	10/21/02	Yes
TLC	EPSDT- Brochure for ages 10-14	11/06/02	12/06/02	Yes
TLC	Winter Newsletter to include EPSDT	10/28/02	11/13/02	No
TLC	Beeper Incentive for EPSDT	10/23/02	11/05/02	No
TLC	EPSDT- Rap Jingle	10/01/02	12/17/02	Yes
Universal Care	Phone Campaign on EPSDT	11/15/02	11/22/02	No
VHP	EPSDT- Member Letter	08/07/02	09/11/02	Yes
VHP	EPSDT- Follow Up Letter	10/03/02	10/30/02	Yes
Xantus	EPSDT Outreach	07/29/02	08/28/02	Yes

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

OFFICE OF CONTRACT DEVELOPMENT AND COMPLIANCE

EPSDT SEMI-ANNUAL REPORT

JULY TO DECEMBER 2002

ATTACHMENT B.

Bureau of TennCare
Office of Contract Development & Compliance

EPSDT TRANSPORTATION REVIEW CHECKLIST

Name of MCC: _____

Name of OCDC Reviewer: _____

Date of Review: _____

Title of Document Reviewed: _____

Date of Document: _____

INTRODUCTION:

This EPSDT Transportation Review Checklist is intended to be a guide and is not all inclusive. It is an attempt to ensure that MCC Member Handbooks, Provider Manuals, EPSDT Marketing Materials, Transportation Policies and Procedures, and Transportation Vendor Subcontracts contain the required language for transportation.

Definition of EPSDT:

EPSDT Services (Early Periodic Screening, Diagnosis and Treatment) of Individuals under age 21 made pursuant to 42 U.S.C. Sections 1396a (a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or an individual basis) physical and mental defects, and providing treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

Reference Documents:

Yes ❑ No ❑ N/A ❑ **John B. Consent Decree:**

Section _____ Page _____

Paragraph 74. The defendants shall ensure that the MCOs meet their responsibilities to provide non-emergency transportation services under Daniels v. Wadley, No.79-3107-NA-CV (M.D.Tenn.).

Yes ❑ No ❑ N/A ❑ **MCO Contract Provision: Section 2-3.a.1.**

Section _____ Page _____

As necessary for enrollees lacking accessible transportation for covered services.

The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment.

EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be

		effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems. worsening of an individual's conditions or preventing the development of additional health problems.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

Section 2-3.u.

2-3.u. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

Section 2-3.u.7.(a)(3)

The MCO must have a mechanism for notifying families when EPSDT screens are due. This mechanism must include an offer of transportation and scheduling assistance.

BHO Contract Provision: Section 2.6.8.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

2.6.8.1.4 Transportation and scheduling assistance. Transportation assistance for a child includes related travel expenses, the cost of meals, and lodging in route to and from care, the cost of an attendant to accompany a child if necessary.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

2.6.8.5 The Contractor shall offer transportation and scheduling assistance to all children under age 21 referred for a mental health or substance abuse assessment.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

2.6.8.6. In the event that the child's parent or legal guardian is unable to accompany the child to the examination, the Contractor shall require providers to contact the child's parent or legal guardian to discuss the findings and inform the parent or legal guardian of any other necessary health care, diagnostic services, treatment or other measures recommended for the child, or notify the BHO to contact the family with the results.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

John B. Consent Decree:

Paragraph 75. The defendants shall prohibit MCOs from imposing blanket restrictions or requirements on transportation to plaintiff class members because of their age or lack of parental accompaniment.

Yes ☐ No ☐ N/A ☐

Section _____ Page _____

MCO Contract Provision: Section 2-3.u.1.(b)(9)

2-3.u.1.(b) (9). Transportation assistance for a child includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary. Blanket restrictions may not be imposed when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case by the CONTRACTOR and documented by the CONTRACTOR and/or the transportation vendor.

The requirement to provide the cost of meals shall not be interpreted to mean that an enrollee and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when an enrollee has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

The CONTRACTOR shall offer transportation and scheduling assistance to all children under age 21 referred for an assessment that do not have access to transportation. This may be accomplished through various means of communication to enrollees, including but not limited to, member handbooks, EPSDT outreach notification, etc.

An EPSDT enrollee may be considered for transportation if such enrollee has written permission from the treating physician and custodial parent(s). Circumstances that may permit the CONTRATOR and/or its transportation vendor to refuse the transportation request would be as follows.

(i) The EPSDT enrollee is under the age of eighteen (18) and does not have an attendant.

(ii) The EPSDT enrollee has an attendant, but the attendant is not a parent or legal guardian and cannot legally sign for the enrollee or stepchild. Some foster or stepparents do not have legal authority to sign for medical care for foster or step children. The CONTRACTOR and transportation vendors must be aware of this and must ask these questions when scheduling transport.

(iii) The enrollee or attendant according to a reasonable person's standards has to be noticeably indisposed [disorderly conduct, intoxicated, armed (firearms), possession of illegal drugs, knives and/or other weapons], and in any other condition that may affect the safety of the driver or persons being transported.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

John B. Consent Decree:

Paragraph 76. The defendants or their contractors shall provide non-emergency transportation in accordance with 42 U.S.C. Section 1396d (a) (25); 42 C.F.R. Section 440.170(a), 441.62; State Medicaid Manual Section 5150. Transportation assistance includes "related travel expenses," cost of meals and lodging in route to and from care and the cost of an attendant to accompany a child if necessary.

Monitoring of BHO Provided Services for DCS Children
October 2002

This report describes the services provided to children in DCS custody. The population includes all children in DCS custody through March 31, 2002 who are SED/SPMI (n = 3,236), and non-priority children (n = 9,577). The data include encounter claims from July 1, 2000 through March 31, 2002, case management logs, and DCS eligibility information from October 2001 to September 2002. Data for children in DCS custody who are receiving treatment in a level 3 or 4 facility, much of which is administered directly by DCS, are not necessarily represented in the encounter data.

Report Highlights:

- There have been 12,813 children in DCS custody sometime between October 1, 2001 and March 31, 2002.
- Of the children in DCS custody, 25% are categorized as priority population.
- 7.8% of the children in DCS custody received a psychiatric inpatient admission.
- Less than 1% of the children in DCS custody received a residential treatment admission.
- 80% of the priority children and 33% of the non-priority children in DCS custody received outpatient services (other than mental health screens).
- 62% of the priority children and 26% of non-priority children in DCS custody received one or more mental health screens at some point between July 1, 2000 and March 31, 2002.
- 33% of the children in DCS custody received mental health case management services at some point from July 2000 to March 2002. This percentage is projected to increase as the BHO and DCS work to ensure that all priority children in DCS custody are offered mental health case management.

Inpatient Utilization

The inpatient encounter data included in this report refer only to the number of admissions to a psychiatric inpatient facility. The table below, *Inpatient Utilization for Children During DCS Custody*, displays the number of unduplicated priority and non-priority children with at least one psychiatric inpatient admission during their time in DCS custody divided into age categories.

Inpatient Utilization for Children During DCS Custody (N = 681)		
	Non-Priority Children	Priority Children
Number of Unduplicated Children	245	436
Age 4 to 12	31 (12.7%)	79 (18.1%)
Age 13 to 17	144 (58.8%)	294 (67.4%)
Age 18 to 20	70 (28.6%)	63 (14.4%)

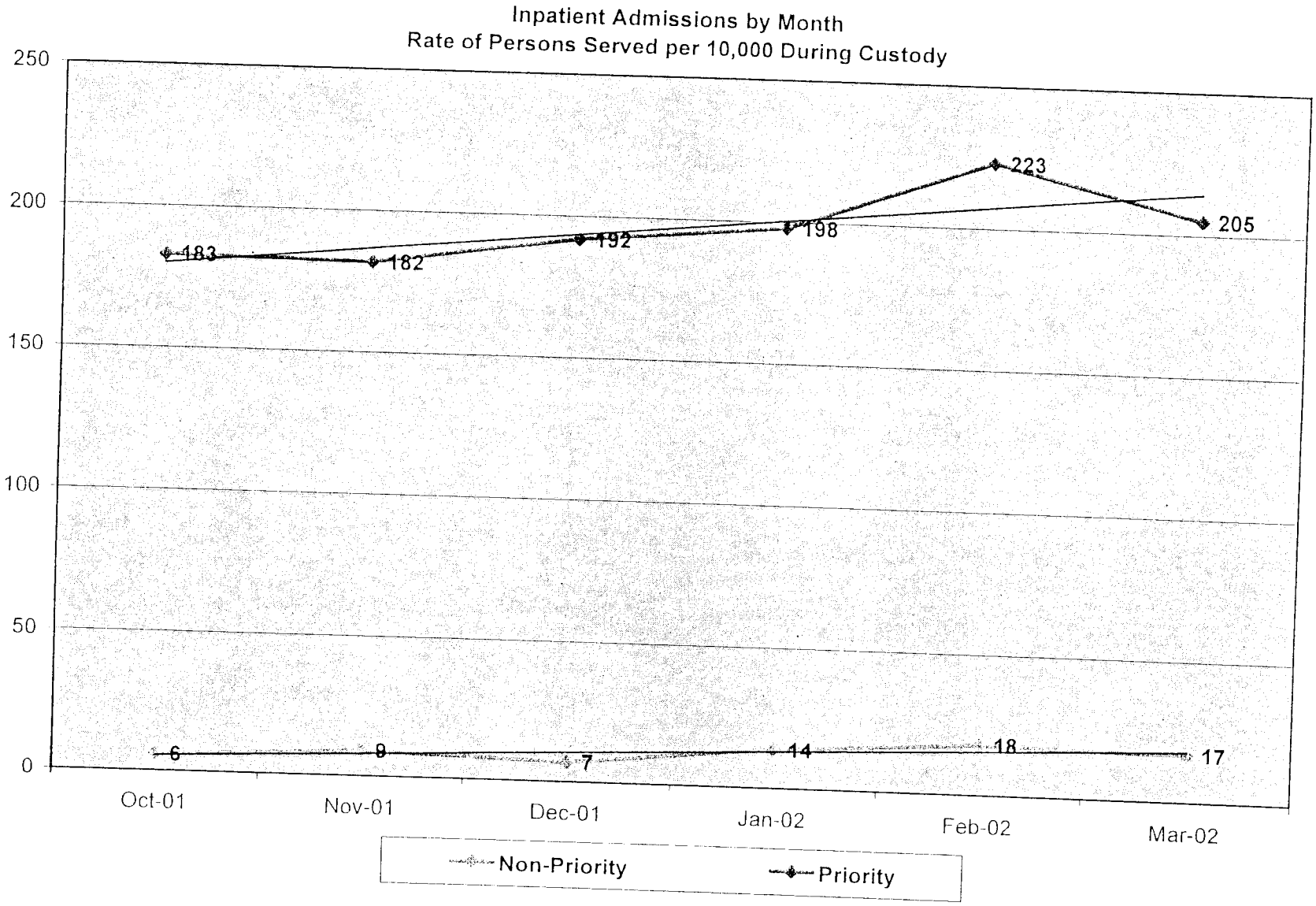
The inpatient service utilization data reveal the following:

- 681 children have experienced at least one psychiatric inpatient admission during their time in custody.
- 64% of the children in custody with a psychiatric inpatient admission were categorized as SED/SPMI.

The following table, *Inpatient Length of Stay per Admission for Children During DCS Custody*, shows the average and median length of stay by days for the non-priority and priority children who had an inpatient admission.

Inpatient Length of Stay per Admission for Children During DCS Custody		
	Average of Days	Median of Days
Non-priority	8.7	6
Priority	10.4	7

The chart provided on the following page illustrates the inpatient utilization for those children who received a psychiatric inpatient admission during their time in DCS custody. These charts show the trends between October 2001 and March 2002 by month.


Inpatient Admissions by Month
Rate of Persons Served per 10,000 During Custody
250
200
150
100
50
0
183
182
192
198
223
205
6
9
7
14
18
17
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
Non-Priority
Priority

Residential Treatment Utilization

The data regarding 24-hour residential treatment reveal the following:

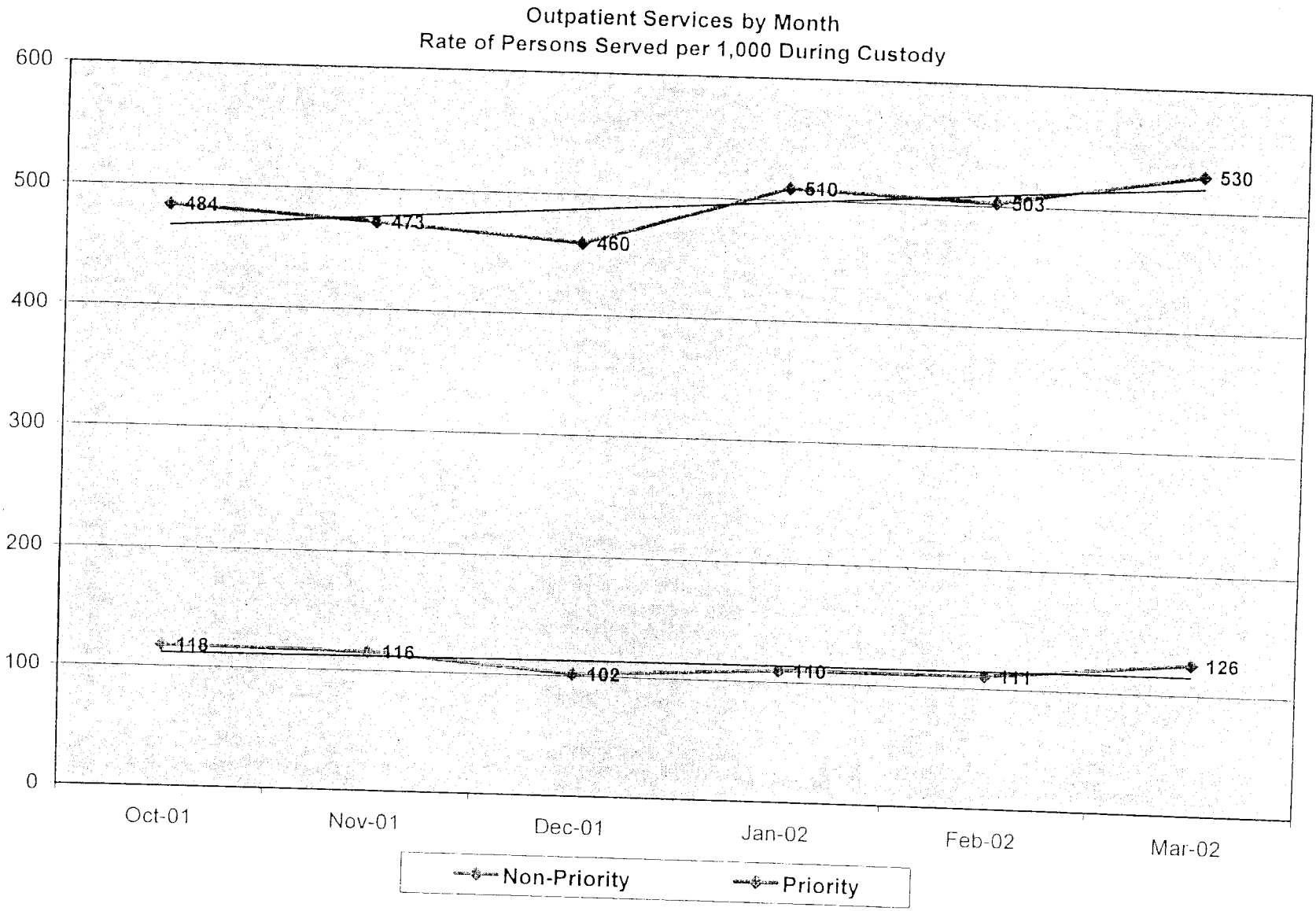
- 7 children received at least one residential treatment admission during their time in DCS custody.
- Of those 7 children, 4 (57%) were categorized as non-priority children and 3 (43%) were categorized as priority children.

Outpatient Utilization

The table below, *Outpatient Service Utilization for Children in DCS Custody*, indicates the number of children who utilized any outpatient service between July 1, 2000 and March 31, 2002 divided into age categories.

Outpatient Service Utilization for Children During Time in DCS Custody (N = 6288)		
	Non-Priority Children	**Priority Children**
Number of Children (Unduplicated)	3554	2734
Under 4 years	26 (.7%)	7 (.3%)
Age 4 to 12	1034 (29.1%)	773 (28.3%)
Age 13 to 17	1716 (48.3%)	1619 (59.2%)
Age 18 to 20	772 (21.7%)	329 (12.0%)
Age 21 and over	6 (.2%)	6 (.2%)

The chart provided on the following page shows the outpatient utilization for non-priority and priority children who received an outpatient service during their time in DCS custody. The chart shows the trends of outpatient services by month between October 2001 and March 2002. According to the outpatient data, the number of outpatient services being received by priority children appears to be increasing over time while the outpatient services for non-priority children appears to be remaining the same.

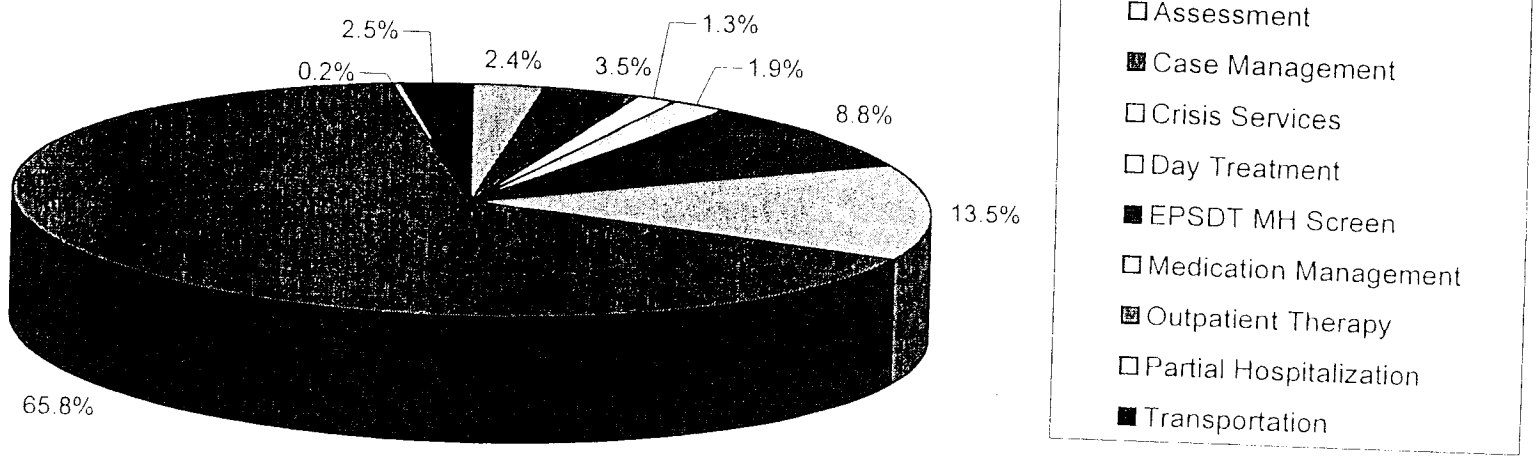

Outpatient Services by Month
Rate of Persons Served per 1,000 During Custody
600
500
400
300
200
100
0
484
473
460
510
503
530
118
116
102
110
111
126
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
Non-Priority
Priority

Outpatient Utilization by Selected Service Types for Children During Time in DCS Custody Between 07/01/00 and 03/31/02				
	Non-Priority Children		Priority Children	
	Number of Services	Number of Children	Number of Services	Number of Children
Assessment	1,117 (2.4%)	585	1,539 (3.1%)	771
Case Management	1,663 (3.5%)	345	4,454 (8.9%)	722
Crisis Services	617 (1.3%)	306	1,389 (2.8%)	526
Day Treatment	885 (1.9%)	20	1,360 (2.7%)	37
EPSDT	4,139 (8.8%)	2,445	4,077 (8.1%)	2,020
Medication Management	6,345 (13.5%)	1,300	8,339 (16.6%)	1,556
Outpatient Therapy	30,857 (65.8%)	2,461	27,472 (54.7%)	2,028
Partial Hospitalization	75 (0.2%)	11	211 (0.4%)	22
Transportation	1166 (2.5%)	96	1,337 (2.7%)	80

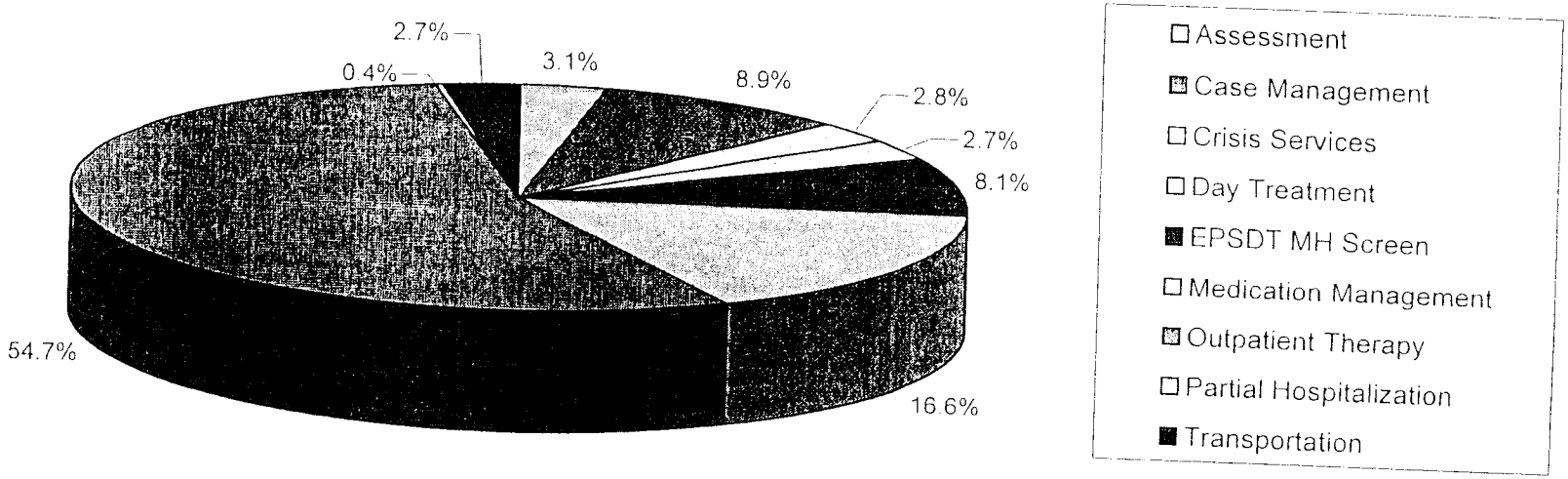
The *Outpatient Utilization by Selected Service Types* table for non-priority and priority children provides information regarding the total number of outpatient services provided to children during their time in custody by the service types. Additionally, the tables indicate the actual number of children who received a specific type of outpatient service. For example, according to the outpatient data for non-priority children during custody, there were 1,663 mental health case management claims (for 345 unique children) during the period of July 1, 2000 through March 31, 2002. The same table also indicates that for priority children during their time in custody, there were 4,454 mental health case management claims (for 722 unique children) during the same time period. According to the data above, outpatient therapy is the most utilized service for both priority and non-priority children. Non-priority children averaged 12.5 outpatient services and priority children averaged 13.5 outpatient services during their time in custody.

The chart provided on the following page shows the distribution of outpatient services provided for non-priority and priority children during their time in DCS custody.

Outpatient Service Types for Non-Priority Children During Custody



Outpatient Service Types for Priority Children During Custody



An analysis was conducted of EPSDT mental health screenings and of the other outpatient services provided in which EPSDT mental health screenings (CPT code 90801) were excluded. The analysis revealed the following:

Outpatient Services and EPSDT Mental Health Screenings		
	Number of Children with At Least One Outpatient Service (Excluding Mental Health Screens)	Number of Children with At Least One EPSDT Mental Health Screen
Non-Priority	3193	2445
Priority	2573	2020

Analysis regarding those children who have received an EPSDT mental health screening indicates the following:

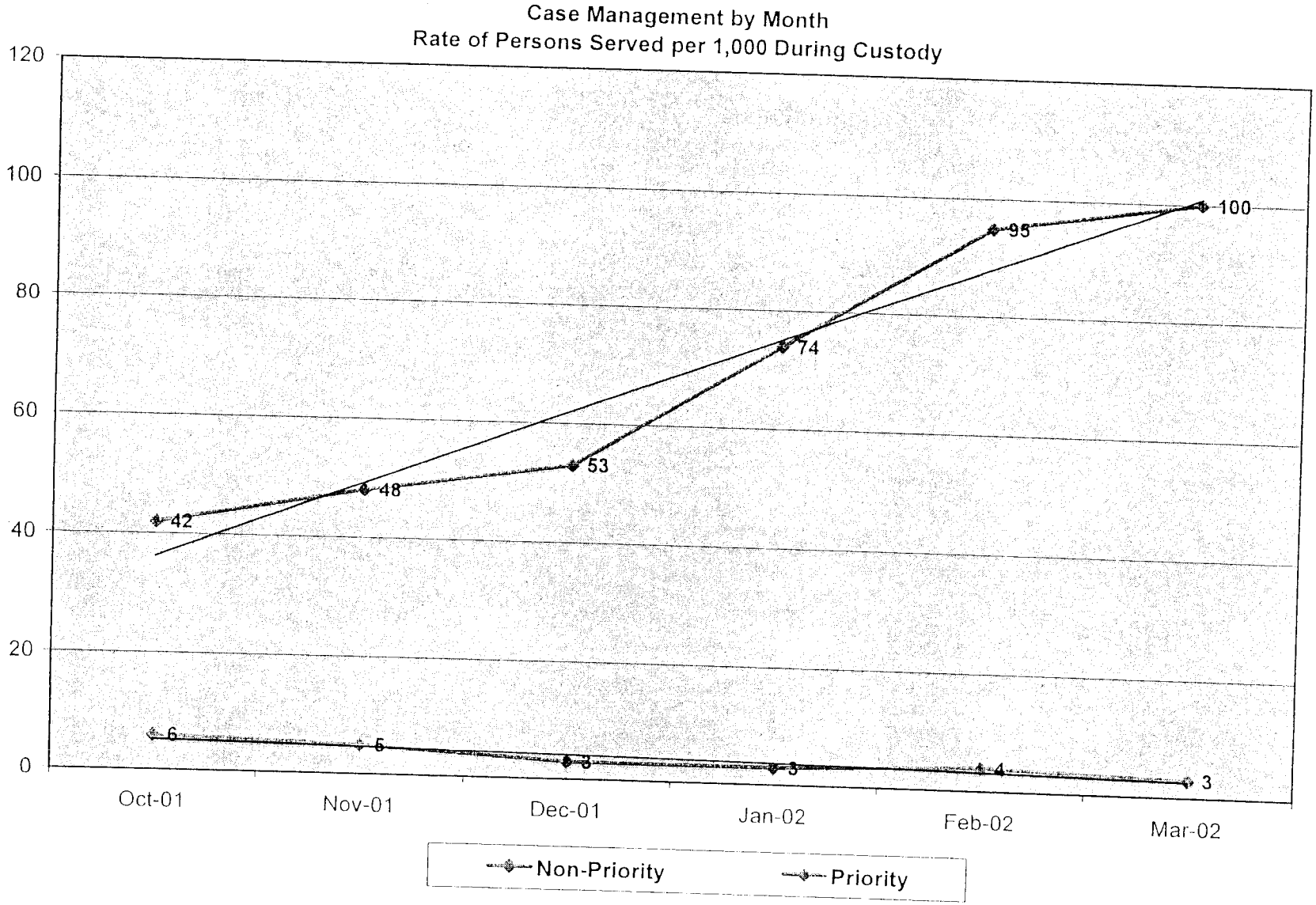
- Overall, 62% of children with a priority assessment in DCS custody (n = 3236) have received an EPSDT mental health screen as compared to only 26% of non-priority children in custody.
- 80% of priority children have received at least one outpatient service, other than mental health screens, during their time in DCS custody as compared to only 33% of non-priority children.

Case Management

The data reviewed regarding mental health case management services reveal the following:

Active Case Management	
	Number of Children with At Least One Active Case Management Service
Non-Priority	345
Priority	722

The following chart shows the trends of active case management encounters for non-priority and priority children from October 2001 through March 2002:


Case Management by Month
Rate of Persons Served per 1,000 During Custody
120
100
80
60
40
20
0
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
42
48
53
74
95
100
6
5
3
3
4
3
Non-Priority
Priority

- 55 children received Continuous Treatment Team (CTT) intensive case management services during their time in DCS custody.
- 24 of those who received CTT during their time in custody have been discharged from CTT services.
- One child in DCS custody received Comprehensive Child and Family Treatment (CCFT) and has been discharged.
- Overall, 93 children discontinued case management services and 73 children were offered case management services but declined the service[1].

[1] The number of declines for case management services are under reported in the encounter data by as much as 80%.

Best Practice Guidelines

Behavioral Health Services For Children and Adolescents

Tennessee
Department of Mental Health
and Developmental
Disabilities

July 2002

Tennessee Department of Mental Health and Developmental Disabilities
Best Practice Guidelines
Behavioral Services for Children and Adolescents

Acknowledgements

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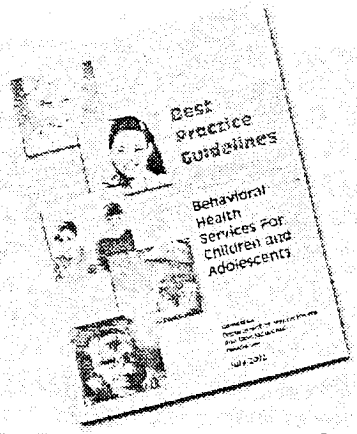
The American Academy of Child and Adolescent Psychiatry
Expert Consensus Guidelines Series, LLC.

TDMHDD wishes to thank the following individuals for their time, efforts, recommendations, and contributions toward the development and collation of these guidelines



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Heather Blane, UT College of Pharmacy
Dana Barnes, UT College of Pharmacy

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Tennessee Department of Mental Health and Developmental Disabilities. Authorization Number 339434. 2,000 copies, October 2002. This public document was promulgated at a cost of $2.56 per copy.

Best Practice Guidelines For Children and Adolescents

Table of Contents

TDMHDD GUIDELINE

Attention-Deficit/Hyperactivity Disorder

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children between five and twelve years of age with "typical" ADHD in the primary care office. Material herein was prepared by Jerry Heston, M.D., University of Tennessee College of Medicine, based on current understanding of the disorder and coordinated with recommendations from professional organizations, primarily the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. The goal of the protocol is to improve the care of children with this disorder. It is not intended to dictate treatment decisions but to provide practitioners, especially those in primary care, with information and support as they care for children with ADHD. Complex cases, cases with significant comorbidity or presentations outside the "typical" age range are beyond the scope of this protocol. Nonetheless, the protocol may serve as a base for modifications in these complicated cases.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, override the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

In a Child Between Five and Twelve Years Old Who Presents With Chief Complaint(s) of:

School problems
Can't stay in seat
Difficulty taking turns
Can't follow instructions
Difficulty completing tasks
Interrupts, intrudes on others
Accident-prone
Difficulty being calm
Over active: fidgety restless
Easily distracted
Blurts out answers
Disruptive behavior
Talks excessively
Acts without thinking
Poor self esteem
"Someone thinks he has ADHD"

Consider ADHD By Using DSM IV Criteria:

CHECK ALL THAT APPLY:
At least 6 of the following symptoms of inattention have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level:*

_____ often fails to give close attention to details or makes careless mistakes in schoolwork
_____ often has difficulty in sustaining attention in tasks or play activities
_____ often does not seem to listen when spoken to directly
_____ often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions)
_____ often has difficulty organizing tasks and activities
_____ often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (ex: schoolwork, homework)
_____ often loses things necessary for tasks or activities (toys, assignments, pencils, books)
_____ is often easily distracted by environmental stimuli
_____ is often forgetful in daily activities

OR
At least 6 of the following symptoms of hyperactivity and impulsivity have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level:*

_____ often fidgets with hands or feet or squirms in seat
_____ often leaves seat in classroom or in other situations in which remaining seated is expected
_____ often runs about or climbs excessively in situations in which it is inappropriate
_____ often has difficulty playing or engaging in leisure activities quietly
_____ is often "on the go" or often acts as if "driven by a motor"
_____ often talks excessively
_____ often blurts out answers before questions have been completed
_____ often has difficulty waiting turn
_____ often interrupts or intrudes on others (butts into conversations or games)

AND

_____ some hyperactive, impulsive or inattentive symptoms *that caused impairment* were present before age 7 years

AND

_____ some impairment from the symptoms is present in two or more settings (ex: school and home)

AND

_____ there is *clear evidence* of clinically significant impairment in social, academic or occupational functioning

AND

_____ the symptoms do not occur only in the course of a pervasive developmental disorder, a psychotic disorder, and/or are not better accounted for by a physiological condition, or by another mental disorder (i.e, Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder)

Confirm Diagnosis Of ADHD With Direct Information From Parents And Teachers Or Other Caregivers:

Request completion of ADHD-specific rating scales (ex.: Abbreviated Conners Scale) by parents and teachers.

Review school-based multidisciplinary evaluations or other school reports and assessments.

Evaluate Presence Of Comorbid Conditions And Differential Diagnoses:

Learning Disabilities may exist where there is irregular achievement in school or when academic functioning is less than might be expected based on service recipient's overall intellect. In about 30% of cases of ADHD, there is an existing learning disability, but it should also be noted that learning disability can often mimic ADHD, especially **inattentive type.** Refer for psycho-educational testing to confirm.

Oppositional Defiant Disorder and **Conduct Disorder** may co-occur with ADHD in about 30% of service recipients. Hallmarks include high levels of defiance or other severely disruptive behavior beyond overactivity and poor attention skills. Consider consultation or referral to mental health care provider for diagnosis and treatment.

Anxiety Disorders with prominent worries, fears and tension may coexist with ADHD. The restlessness and fidgetiness of Anxiety Disorders may resemble ADHD and should be considered in the differential diagnosis. Consider consultation or referral to mental health care provider.

Depressive Disorders may coexist with ADHD, especially in service recipients who have experienced numerous failures or other stresses and have developed depressive thought patterns that begin to influence their outlooks. Some of these children may respond to support and experiencing success instead of failure. Others may require consultation or referral to mental health care provider. Depression is often seen in adolescents with ADHD who may not have been diagnosed and treated properly as younger children so that they have attributed their difficulties to bad behavior or other self problems rather than to a treatable condition. Some of these teens have turned to substance abuse as a means of self-medicating or as a means to a social group. Assessment of substance use/abuse should be included when considering adolescents with ADHD.

Various **social stressors** including adjustment problems, family disruption or physical and sexual abuse can both coexist and resemble the symptoms of ADHD. A careful and complete social history should be completed. Referral to mental health care providers or other agencies may be needed.

Discuss Treatment Options With Service recipient And Family:

Treatment should be **multi-dimensional** and include education, counseling, classroom/school modifications and medication depending on the specific needs of each individual child and family.

The child and parents should be educated about the diagnosis and encouraged to understand that this condition represents a challenge to overcome, not an "excuse" for misbehavior. Strengths and relative weaknesses should be identified. The variations in the presentation and the course of the disorder should be reviewed. Encouraging parents to become advocates for their child and informing them of their options is a part of education that may be done in the primary care office.

MEDICATION THERAPY:

Plan A:
Stimulant medications, either methylphenidate (Ritalin) or amphetamine (Dexedrine, Adderall), are first line medications in the treatment of ADHD. Discuss the indications, possible side effects (decreased appetite, sleep disturbance, headaches, moodiness) and an overall treatment plan with the parents. If consent is obtained begin treatment with low doses of stimulant medication in two to three daily divided doses, each about three to four hours apart (ex: 8AM, 12 N, 4PM).

Based on response and side effects, the dose can be adjusted fairly rapidly, once a week, to a maximum of 2mg/kg/day or 60mg/day of methylphenidate or 1mg/kg/day or 60mg/day of an amphetamine preparation. Most children with ADHD require doses less than the maximum. Lack of response to near maximum doses indicates a need to review the diagnosis and/or consideration of another medication.

Periodic follow up by phone calls and/or office visits should address response, compliance, side effects and overall functioning. Information for school staff is very useful in monitoring response to medications.

If a good response to first line stimulant is documented, changing to a long acting preparation of the same stimulant may be indicated for convenience and improved compliance.

Consideration should be given to "medication holidays"(periods off medication). The indications for these are debatable. However, in consideration of parental desires, the severity of service recipient symptoms (e.g., Is family life disrupted by symptoms? Is peer interaction compromised?) and the activities in which the child participates (example: summer vacation may not be a good time for a medication holiday for a child who is taking classes in summer school) medication-free periods may be desirable. Some knowledge about continued need for medication may be gained during these periods.

If poor response is seen to first line stimulant, go to Plan B.

Plan B:
Lack of response to one stimulant does not indicate poor response to other stimulant medications. Therefore, start treatment with a second stimulant medication (amphetamine, if methylphenidate used in Plan A or vice versa). Methods of dosing and monitoring follow up are as in Plan A.

If poor response is seen, consider Plan C.

Plan C:
Consider treatment with pemoline (Cylert) a third available stimulant. Because of rare, fatal liver toxicity some clinicians may elect to bypass this step. Because of a longer half-life, once a day dosing is possible. Doses begin at 18.75 mg and may be increased in two to three weeks depending on response and side effects. Due to the longer half-life, response may take one to two weeks to occur. Frequent laboratory monitoring of hepatic enzymes (every two to three weeks) can be problematic and limits this option.

Plan D is considered by clinicians that opt against Plan C or for service recipients that do not respond to pemoline.

Plan D:
Tricyclic antidepressant medications have been shown to be useful in children with ADHD. Due to side effects, high overdose toxicity and poorer response rates than stimulants, these medications are thought of as third and fourth line medication interventions. Imipramine (Tofranil) is recommended. Due to possibly higher cardiac effects, desipramine (Norpramin) is not recommended. Pretreatment screening should include family history of cardiac arrhythmias, physical exam, general laboratory screens and an EKG. Side effects (sedation, increased appetite, tremors, and cardiovascular symptoms) are discussed with the service recipient and family. Dosing is started at 25 mg/day in once daily dosing.

The dose is gradually increased based on response and side effects. It may take one to two weeks to observe a clinical response, so dose should not be increased more frequently than weekly. Doses above 2-3mg/kg/day are associated with increased adverse events. Doses higher than this merit reconsideration of the diagnosis and consultation with specialists.

Response, including reports for school staff, should be monitored along with occurrence of side effects and overall functioning. EKG should be monitored throughout treatment, especially at increased doses.

Adjunct Therapies:

Various forms of counseling may be the major intervention for mild cases of ADHD. **Behavioral therapy** can be used to modify behavior using behavioral plans which target specific behavior, outline rewards and address how the plan is to be modified after success. **Family therapy** can be used to change family interactional patterns that may cause dysfunction and improve communication and other family functions to encourage the child with ADHD to rely upon his strengths. Parent training has been proven to be a very effective treatment for children with ADHD, especially when combined with appropriate medications, and parent support groups are an important adjunct to treatment. Various forms of **individual counseling** may be indicated for children with problems coping or other co-morbid conditions (e.g. social skills training). While general behavioral therapy may be done in the primary care office, other, more formal counseling and therapy, should be referred to a mental health care provider.

Consider Referral To Specialist In Developmental Pediatrics Or Child Psychiatry:

Using these guidelines it is estimated that about 90% of children with ADHD will show significant response in the primary care setting (in conjunction with educational and counseling interventions). Lack of response to these interventions indicates need for re-evaluation and possible referral to a specialist in developmental pediatrics or child psychiatry.

TDMHDD Guideline

Anxiety Disorders in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with anxiety disorders in primary care and behavioral health treatment settings. These guidelines are based on the following source material:

> *Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders*. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with anxiety disorders and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Hypoglycemic episodes
Hyperthyroidism
Cardiac arrhythmias
Caffeinism
Pheochromocytoma
Seizure disorders
Migraine
CNS disorders- delirium, brain tumor
Personality disorders
Pervasive developmental disorders
Mood disorders
ADHD
Substance abuse disorders
Eating disorders
Schizophrenia
Medication reaction: antihistamines, antiasthmatics, sympathomimetics, steroids, haloperidol, pimozide, SSRIs, antipsychotics, OTC's (diet pills, cold meds., etc.)

DSM-IV Criteria

Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.
    1. restlessness or feeling keyed up or on edge
    2. being easily fatigued
    3. difficulty concentrating or mind going blank
    4. irritability
    5. muscle tension
    6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Social Phobia

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note**: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note**: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
C. The person recognizes that the fear is excessive or unreasonable. **Note**: In children, this feature may be absent.
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
F. In individuals under age 18 years, the duration is at least 6 months.
G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

A. A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feeling of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, lightheaded, or faint
9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. fear of losing control or going crazy
11. fear of dying
12. paresthesias (numbness or tingling sensations)
13. chills or hot flushes

B. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
   1. persistent concern about having additional attacks;
   2. worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy");
   3. a significant change in behavior related to the attacks

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):
   1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
   2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
   3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
   4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):
   1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
   2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Posttraumatic stress disorder- *(see full guideline in this manual for additional information)*

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Other phobias

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note**: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
C. The person recognizes that the fear is excessive or unreasonable. **Note**: In children, this feature may be absent.
D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
F. In individuals under age 18 years, the duration is at least 6 months.
G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Separation anxiety

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
    1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
    2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
    3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
    4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
    5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
    6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
    7. repeated nightmares involving the theme of separation
    8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
B. The duration of the disturbance is at least 4 weeks.
C. The onset is before age 18 years.
D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with Agoraphobia.

Therapy

Behavioral therapy targets the service recipient's overt behavior and emphasizes treatment within the context of family and school instead of focusing on the etiology of the behavior.

Cognitive-behavioral treatment integrates a behavioral approach with an emphasis on changing the cognitions associated with the service recipient's anxiety.

Psychodynamic psychotherapy derives from child psychoanalysis and includes a greater participation of the parents/caregivers and a more explicit use of active support, practical guidance, and environmental interventions. Therapy directed to fears and anxieties underlying the disorder is often an appropriate component of treatment.

Parent-child interventions may include helping parents/caregivers encourage children/adolescents to face new situations rather than withdrawing, refraining from excessive criticism and intrusiveness, responding to children's needs, and encouraging children to engage in activities despite anxiety. Infant-parent psychotherapy is recommended where there are attachment problems.

Family therapy is also used to disrupt the dysfunctional family interactional patterns that promote family insecurity and to support areas of family competence.

Psychoeducation is important in the treatment of panic disorder.

Pharmacological Treatment

Pharmacotherapy should never be used as the sole intervention. Pharmacotherapy should be used only as an adjunct to behavioral or psychotherapeutic interventions. Selection of the appropriate medication is primarily based on comorbid conditions if they exist. For a child/adolescent with ADHD or enuresis, a tricyclic antidepressant is the drug of choice. A child with comorbid obsessive-compulsive disorder would benefit the most from an SSRI. Side effect profile should also be considered when selecting medication therapy.

Benzodiazepines are often used on a short-term basis, and in the case of severe anxiety, benzodiazepines may be used in conjunction with an SSRI or TCA for several weeks until the antidepressant begins to show beneficial effects.

Treatment Steps

1. Determine onset and development of symptoms and the context in which the symptoms occur and are maintained.
   a. Is anxiety stimulus specific, spontaneous, or anticipatory?
   b. Is avoidant behavior present?
   c. Do comorbid symptoms exist?

2. Explore service recipient's developmental history including temperament, ability to soothe self or be soothed, quality of attachment, adaptability, stranger and separation responses, and childhood fears.
3. Obtain medical history, medication history, school history, social history, and family history.
4. Interview service recipient and conduct a mental status exam.
5. Conduct family assessment and evaluate parent-child relationship.
6. Refer for IQ, psychological, learning disability, and speech and language testing if indicated.
7. Establish diagnosis
   a. Consider physical conditions that may mimic anxiety disorders.
   b. Screen for psychiatric disorders that may be comorbid with or misdiagnosed as anxiety disorders.
   c. Consider that more than one anxiety disorder may be present.
8. Education of parents and other significant persons about symptoms, clinical course, treatment options, and prognosis.
9. Consult and collaborate with school personnel.
10. Begin behavioral or psychotherapy depending on the diagnosis.
    a. separation anxiety disorder
       - behavioral program involving child/adolescent, parents, school personnel, and other appropriate persons
       - family interventions including family therapy, parent-child interventions, and parental guidance
       - psychotherapy including cognitive-behavioral therapy and psychodynamic psychotherapy
    b. other anxiety disorders
       - psychotherapy including cognitive-behavioral and behavioral therapy techniques
       - psychodynamic psychotherapy
       - family interventions
    c. social phobia
       - cognitive-behavioral therapy and behavioral therapy
       - individual or group psychotherapy
       - family intervention
    d. other phobias
       - behavioral and cognitive-behavioral therapy
       - complicated cases may require individual and group psychotherapy
    e. panic disorder
       - cognitive-behavioral therapy
       - individual psychodynamic, group, or family psychotherapies
    f. obsessive-compulsive disorder
       - cognitive-behavioral therapy
       - therapist-assisted exposure and response prevention
    g. posttraumatic stress disorder (see also, guideline for PTSD, p. 45)
       - cognitive-behavioral therapy
       - exposure therapy
       - family therapy
       - discussion groups or peer counseling groups

11. Begin pharmacotherapy depending on the diagnosis and severity.
    a. separation anxiety disorder- in severe cases use a benzodiazepine +/- TCA* or SSRI
    b. other anxiety disorders- in severe cases use a benzodiazepine +/- TCA* or SSRI
    c. social phobia- SSRI
    d. other phobias- pharmacotherapy rarely used
    e. panic disorder- SSRI or TCA +/- benzodiazepine
    f. obsessive-compulsive disorder- SSRI or clomipramine
    g. posttraumatic stress disorder- antidepressant of choice

*Trazodone is often effective in these cases.

TDMHDD GUIDELINE

Bipolar Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with bipolar disorder symptoms in primary care and behavioral treatment settings. Portions of this guideline are adapted from the following sources:

> Practice parameters for the assessment and treatment of children, adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):157S-177S [120 references]
>
> Treatment algorithms incorporated within this guideline were developed by Catherine Fuchs, M.D., Vanderbilt University Medical Center.

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with bipolar disorder and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Agitated Depression
ADD/ADHD or Conduct Disorder
Schizoaffective disorder
Neurological disorders
Substance-Induced Mood Disorder
Organic affective disorders
Schizophrenia
Posttraumatic stress disorder
Metabolic conditions

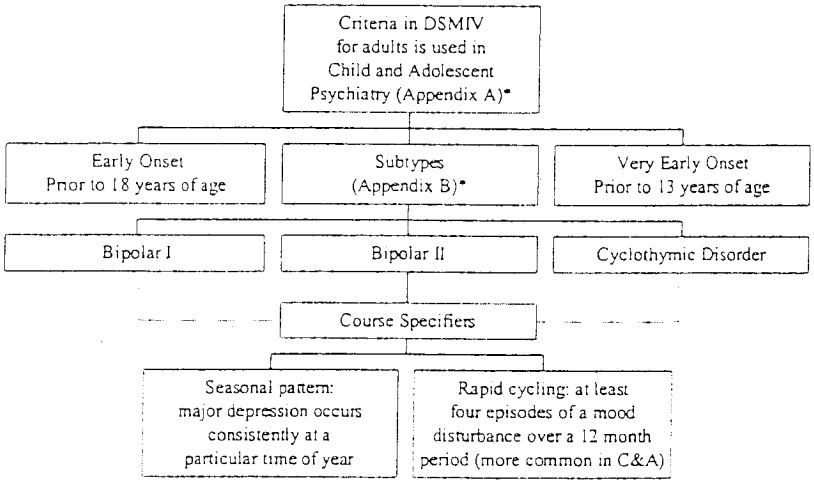
DSM-IV Criteria

A diagnosis of bipolar disorder is made when the required DSM-IV target symptoms for mania/mixed state are present, either currently or by history, and other disorders, such as schizophrenia or organic affective disturbances, have been adequately ruled out. Once the diagnosis has been established, it should be reassessed longitudinally to ensure accuracy.

Specify Subtypes according to DSM IV (Bipolar I, Bipolar II, or Cyclothymic Disorder). Additionally specify early onset if first occurrence is prior to age 18, and very early onset if first occurrence is prior to age 13.

Specify Course of illness. Seasonal pattern is specified if major depression occurs consistently at a particular time of year. Rapid cycling is specified if there are at least 4 episodes of mood disturbance over a 12-month period. Rapid cycling is more common in children and adolescents.

Bipolar Affective Disorder in Children & Adolescents



Exclusion criteria Appendix C*

*Appendices A, B and C refer to DSMIV

Evaluation

Diagnostic Assessment:

- *Premorbid history*
- *History of present illness*
- *Family history and dynamics*
- *School information*
- *Consultation and collaboration with other mental health and/or social service providers as necessary.*
- *Past medical history*

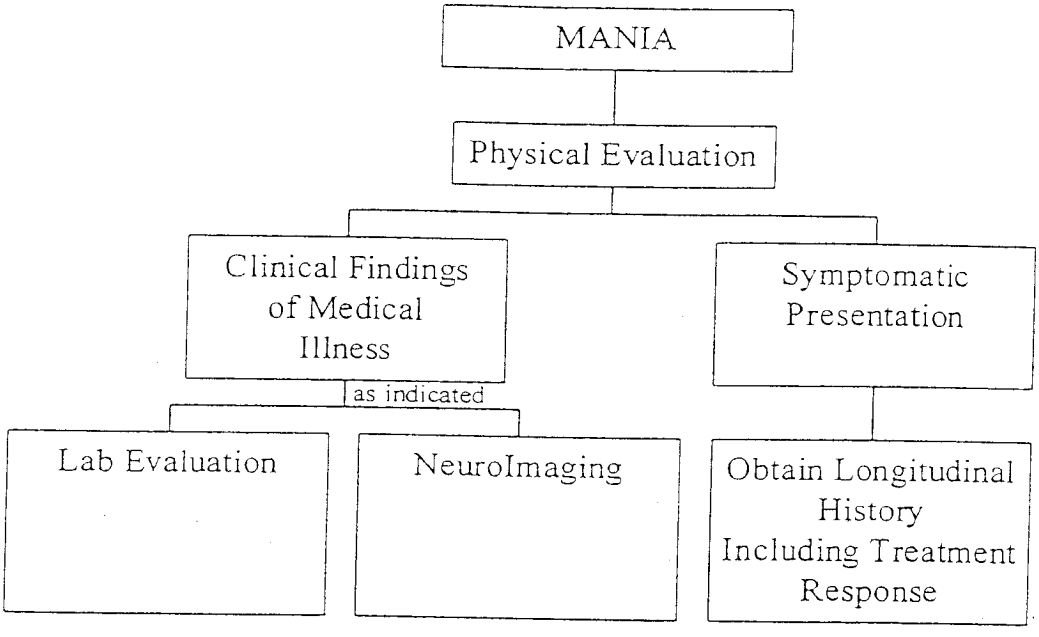
Assessment of suicide risk

Rule out other disorders and determine if necessary to hospitalize

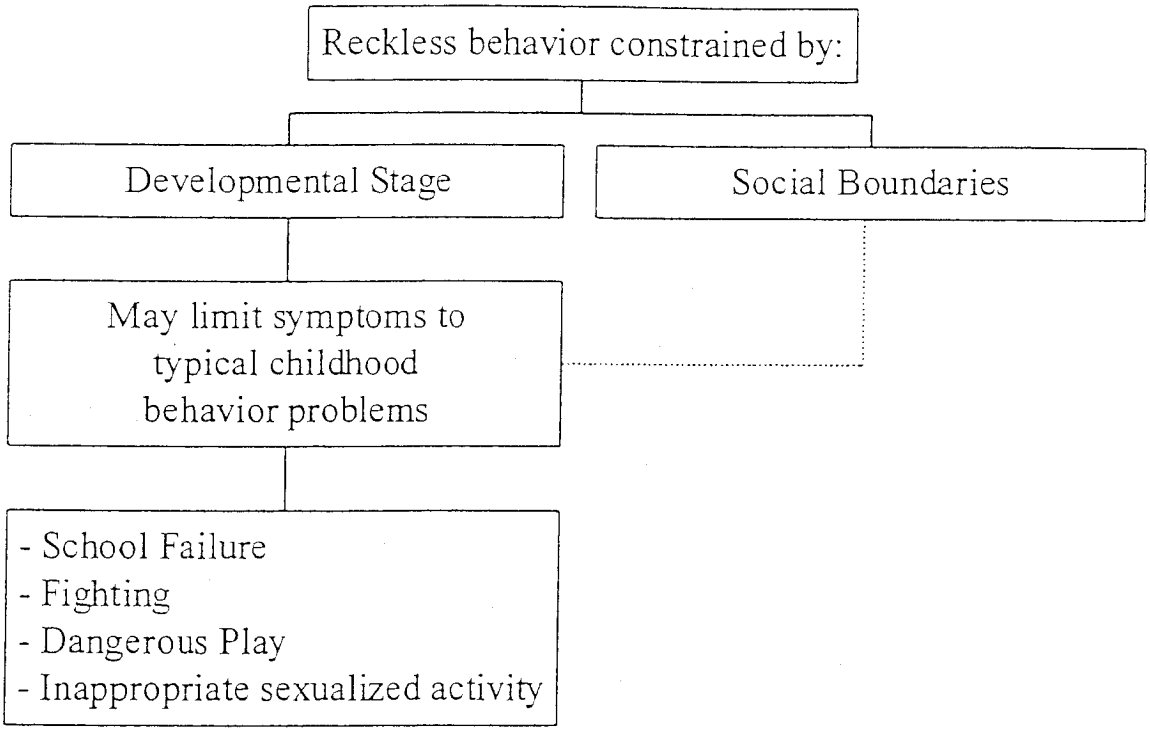
- *Neuropsychological functioning*
- *Substance-induced mood or symptoms*
- *Physical evaluation of the child to rule out organic conditions*

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

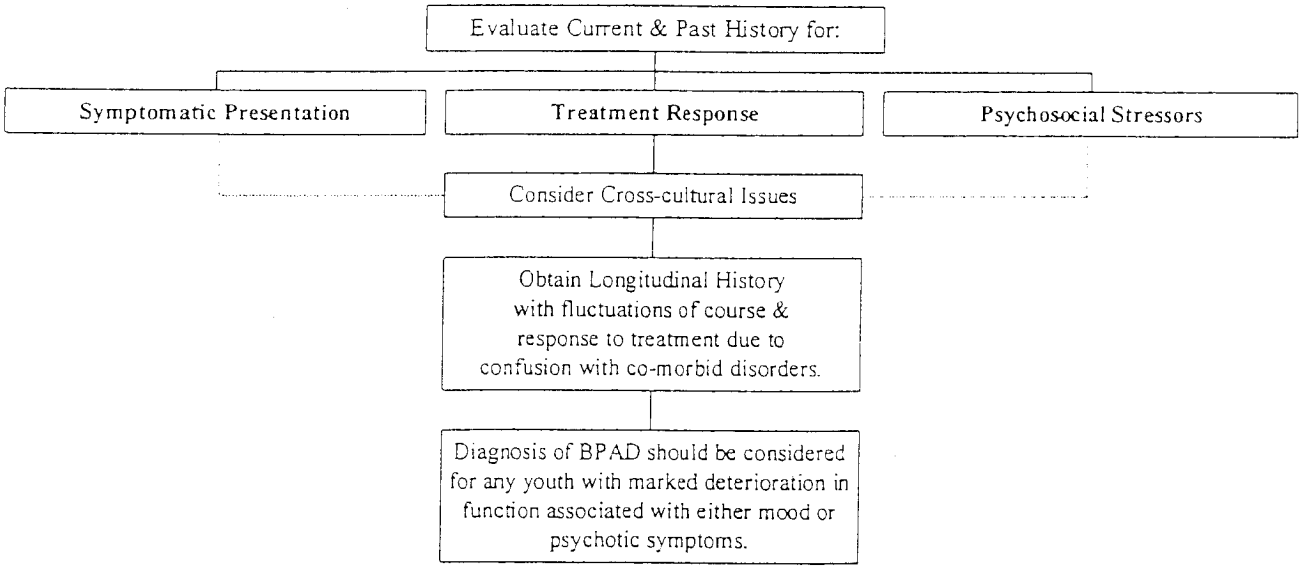
Assessment of Manic Symptoms



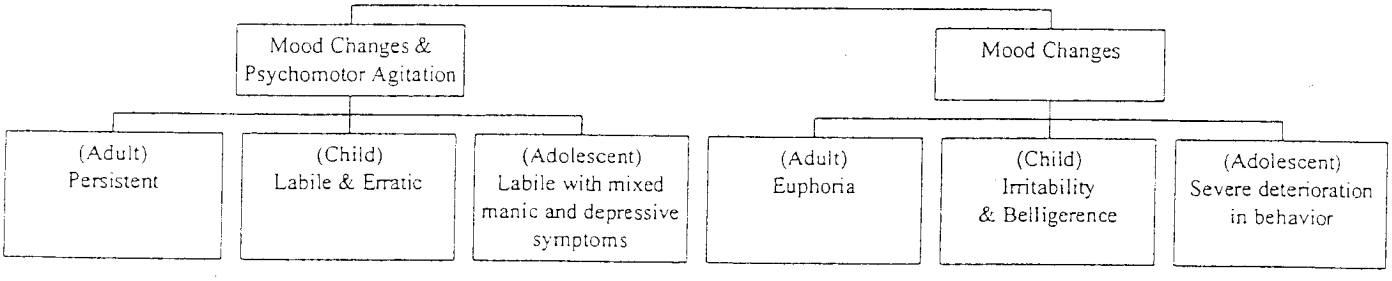
Developmental Issues



Diagnostic Issues



Presentations in Mania



Long Term Treatment Plan

Medication management	Educational and supportive services for the family
Periodic reassessments to ensure accuracy of diagnosis & plan	Educational and vocational services
Appropriate psychotherapy	Case management, as indicated for chronically disabled individuals
Psychoeducational services for the service recipient and family	Residential services when indicated

Medication Therapy

Pharmacotherapy by Symptom Presentations

Symptom Type	Pharmacotherapy – Primary	Pharmacotherapy – Secondary
In remission	Maintenance Dosage for 18 months	
Rapid Cycling	Depakote or Tegretol individual or in combination (Avoid Antidepressants)	Atypical Antipsychotics
Mixed State	Depakote or Tegretol	If psychotic features - Atypical Antipsychotics
Depression	Depakote, Lithium, or Tegretol	If Persistent Depression – Antidepressants as adjunct only due to risk of inducing mania or rapid cycling
Mania	Lithium – Predicators of poor response – psychosis, mixed state, comorbid behavior disorder or substance abuse	If Partial response - Depakote or Tegretol
Mania (Agitated)	Use above with Benzodizapines for acute phase	If partial response – agitated psychotic, neuroleptics for acute phase

ECT

The use of ECT for persons under eighteen years of age requires strict adherence to procedural safeguards set forth in T.C.A. Title 33, Chapter 8, part 3. Indications and important considerations regarding the use of ECT in children are otherwise discussed fully in the complete AACAP practice Parameter, cited above. A careful reading of both the statute and the practice parameter is necessary to any consideration of this intervention.

Other Treatment Modalities to be considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with bipolar disorder, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least nine months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- for the service recipient
- for the family

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's bipolar disorder *should not* be used.)

Cognitive-behavioral therapy to address inappropriate or negative thought patterns and behaviors associated with the illness.

Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality.

Partial hospitalization or day treatment programs Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings.

Residential treatment

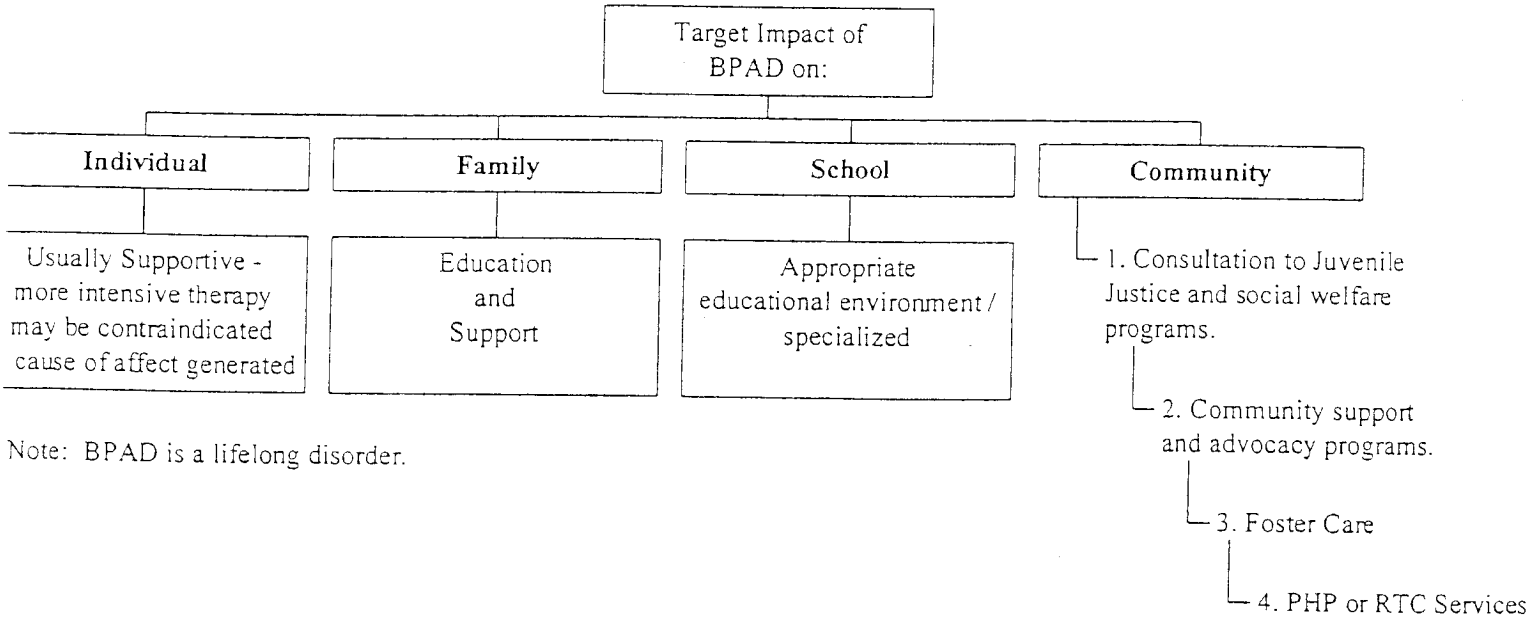
Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting, when less restrictive alternatives have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Psychosocial Rehabilitation

Effective treatment may require a flexible array of services and supports, including case management, in-home services, family support, and school-based services. Supports and services of this kind are individualized and are designed to ameliorate the physical, mental, cognitive or developmental effects of bipolar disorder.

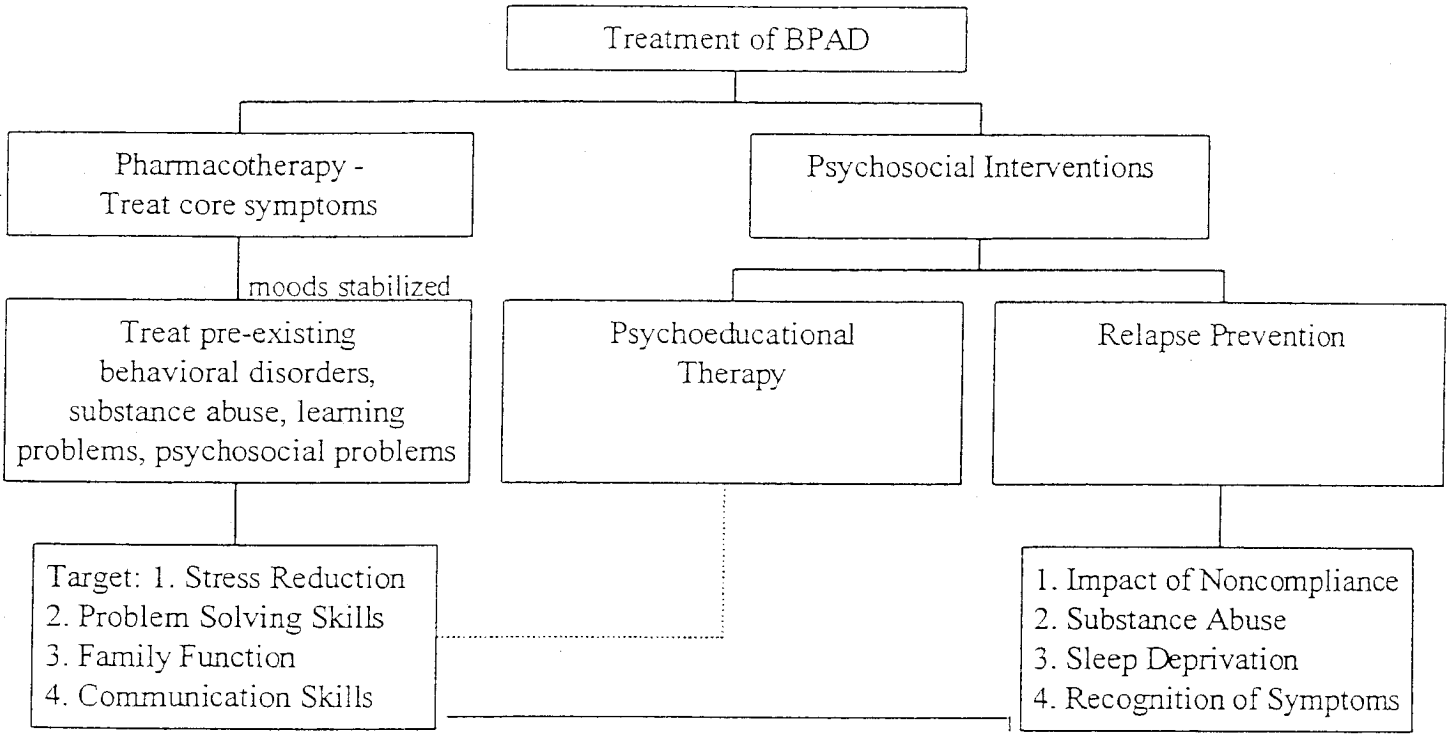
Systems of care serving persons with bipolar disorder who are high service users should include assertive case management and assertive community treatment programs. These programs should be targeted to individuals at high risk for repeated rehospitalizations or who have been difficult to retain in active treatment with more traditional types of services.

Therapy for BPAD

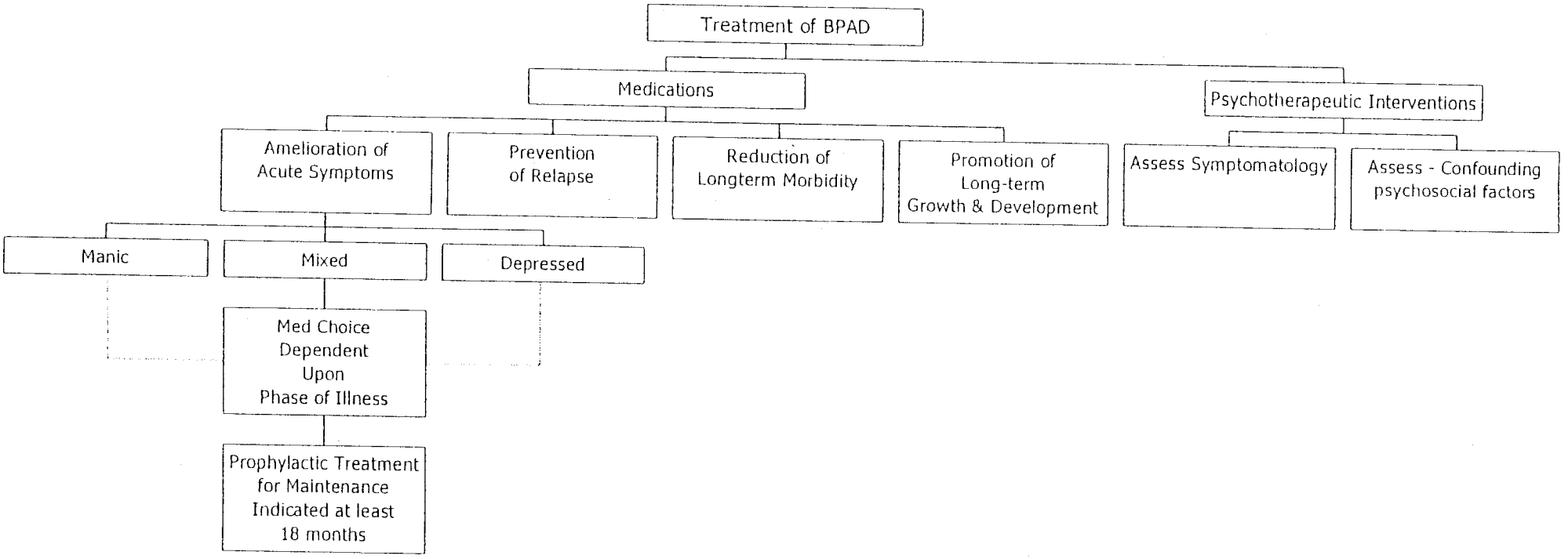


Note: BPAD is a lifelong disorder.

Treatment of BPAD



Treatment of BPAD



TDMHDD GUIDELINE

Evaluation and Treatment of Conduct Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with conduct disorder in primary care and behavioral treatment settings. Portions of this guideline are based on the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with conduct disorder.* J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):122S-139S
>
> Decision trees and essential outline materials were furnished by Martha Wike, Ph.D., Consulting Psychologist, Tennessee Department of Children's Services

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Oppositional defiant disorder	Adjustment disorder
ADHD (may be comorbid)	Mood disorders (may be comorbid)
Substance abuse (may be comorbid)	Child or adolescent antisocial behavior (see DSM-IV v71.01)
Medical disorders	Developmental disorders
PTSD	Schizophrenia
Personality disorders*	

* According to DSM-IV, Antisocial Personality Disorder cannot be diagnosed in a person under age eighteen; other personality disorders must have been pervasive and persistent for at least one year to be diagnosed in someone under age eighteen.

DSM-IV Criteria

Conduct Disorder, as defined by the DSM-IV, consists of a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past six months:

- Must have three (3) or more:

→ Aggression to people or animals
→ Destruction of property
→ Deceitfulness or theft
→ Serious violation of rules

- The disturbance in behavior causes clinically significant impairment
- If eighteen or older, not Antisocial Personality

Assessment

- **Service recipient** interview (with and without parents) ...assess mental status, impulse control, capacity for attachment, trust and empathy, tolerance for negative emotions
- Parent interview ...assess developmental hx, family hx of mood and thought disorders, impulse control and substance abuse disorders, personality disorders
- Collateral contact interviews (school, court)
- Physical exam, including urine or blood drug screen, if drug use is suspected

Treatment

Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of conduct disorder includes intervention in the family, school, and peer group. Typically, several of the following treatment modalities are used in conjunction in order to provide a comprehensive model. Wrap-around approaches, Multi-Systemic Therapy (MST) and Continuing Comprehensive Family Treatment (CCFT) are all noted as effective approaches to Conduct Disorder.

- Treat comorbid disorder

- *Family interventions* include parent guidance, skills training and family therapy.

→ Work on parenting strengths ...eliminate too harsh and too permissive approaches
→ Treat parental pathology

- *Individual and group psychotherapy* with adolescent or child. The technique of intervention should be adapted to child's age, processing style, and ability to engage in treatment.

→ Group therapy is important with adolescents
→ Individual therapy, alone, is ineffective

- *Psychosocial skill-building training.*

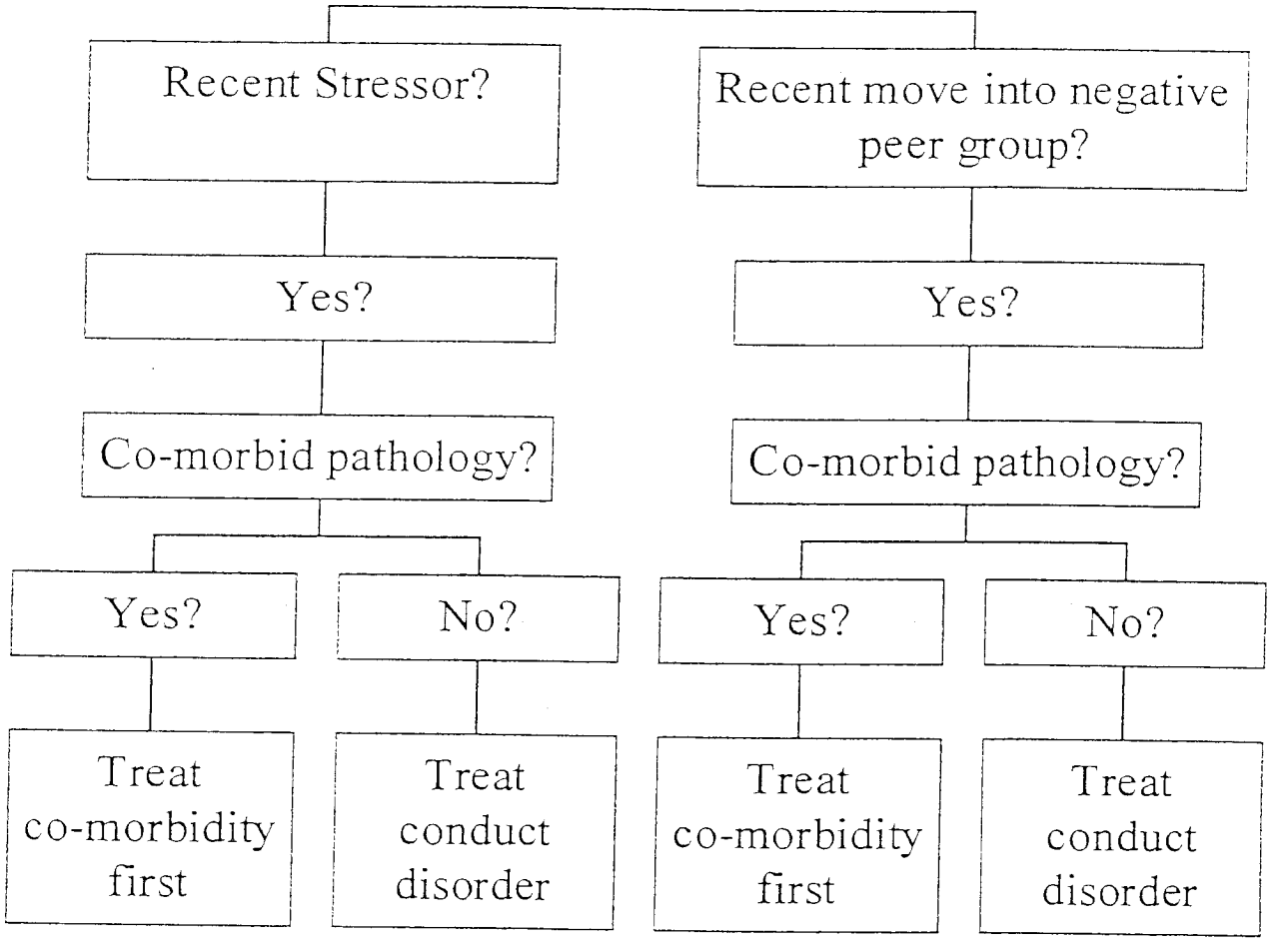
→ Child training to improve peer relationships
→ Child training to improve academic skills
→ Child training to improve compliance with demands from authority figures
→ Social skills building

- *Other psychosocial interventions* should be considered as indicated. Some interventions to consider are peer intervention, school intervention for appropriate placement, juvenile justice system intervention, social services, community resources, out-of-home placement, and job and independent-living skills training.

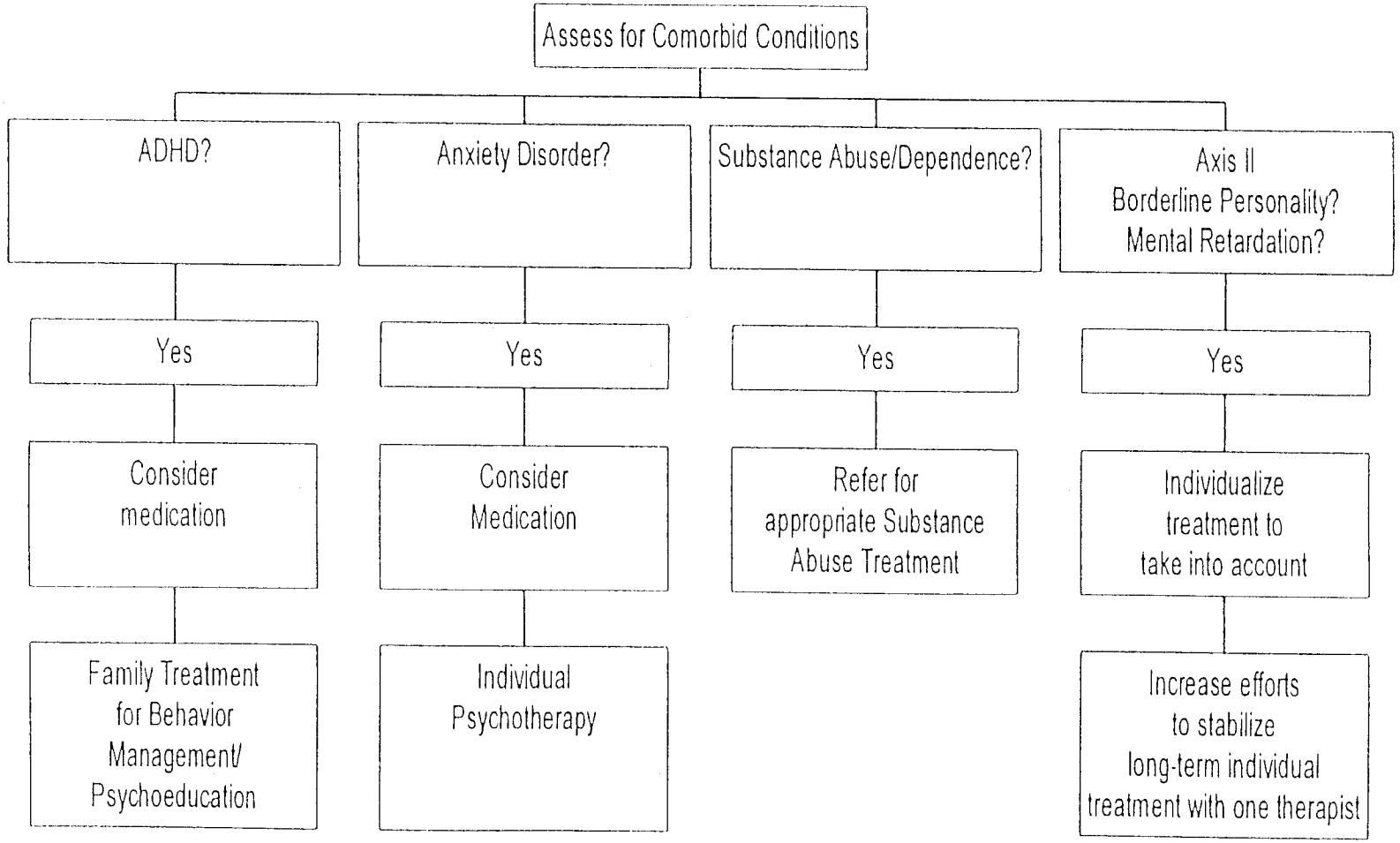
- *Psychopharmacology*. Medications are recommended only for treatment of target symptoms and comorbid disorders and are recommended only on the basis of clinical experience.

- *Level of care decision-making*. Level of care should be the least restrictive level of intervention that fulfills both the short and long-term needs of the service recipient.

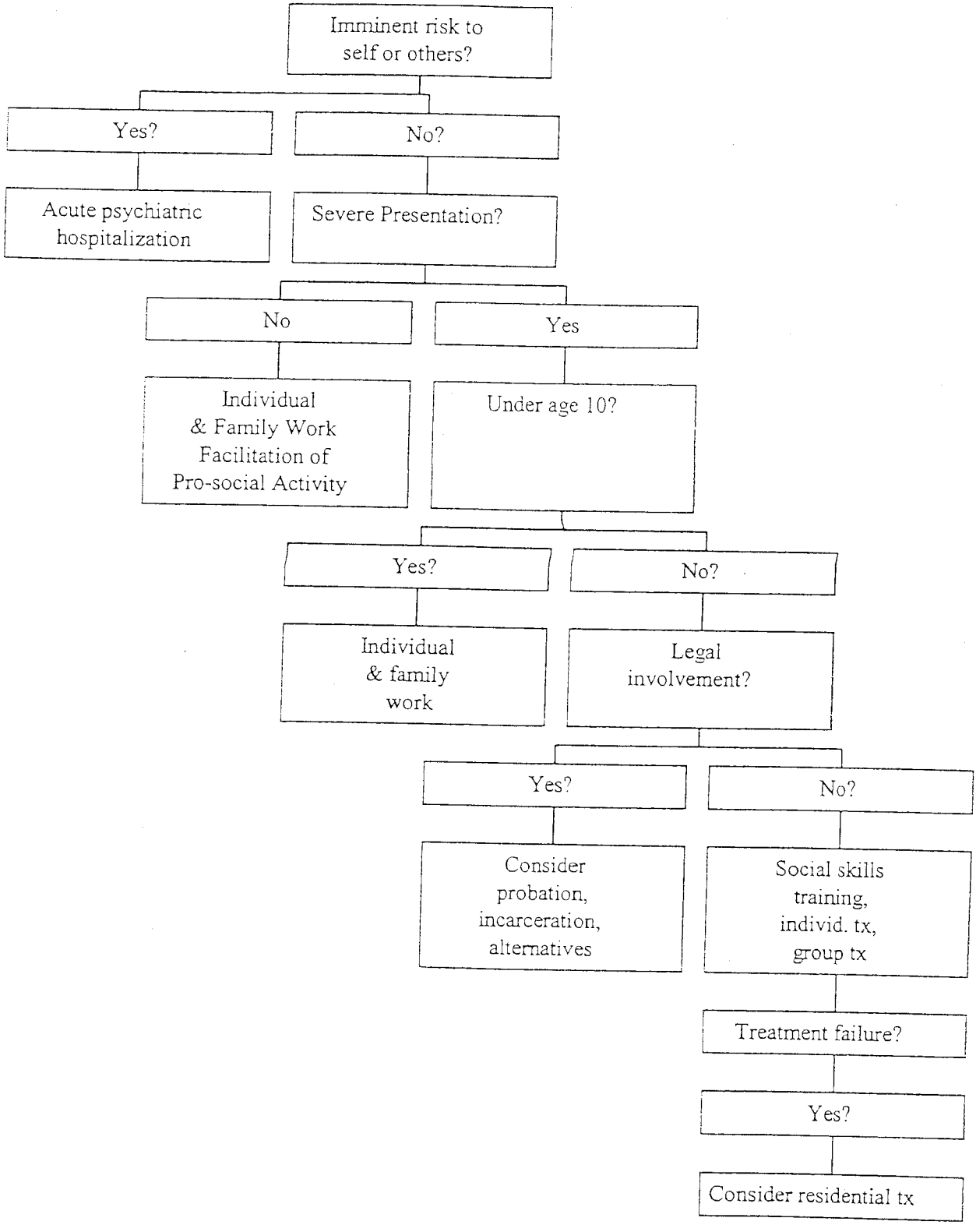
Decision Tree for Conduct Disorder



Assessment


Assess for Comorbid Conditions
ADHD?
Anxiety Disorder?
Substance Abuse/Dependence?
Axis II
Borderline Personality?
Mental Retardation?
Yes
Yes
Yes
Yes
Consider
medication
Consider
Medication
Refer for
appropriate Substance
Abuse Treatment
Individualize
treatment to
take into account
Family Treatment
for Behavior
Management/
Psychoeducation
Individual
Psychotherapy
Increase efforts
to stabilize
long-term individual
treatment with one therapist

Conduct Disorder Treatment



TDMHDD GUIDELINE

Depression in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with depressive disorders in primary care and behavioral treatment settings. These guidelines are adapted from:

> *Practice parameters for the assessment and treatment of children and adolescents with depressive disorders.* J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):63S-83S [231 references]

The user may wish to consult the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with depression and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inservice recipient mental health service providers to maintain treatment review committees for service recipients admitted to inservice recipient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment

- Comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and collateral informants, such as teachers and social services personnel
- Evaluation performed by a clinician trained to consider how developmental and cultural factors impact the service recipient's clinical presentation
- Performance of a developmentally appropriate mental status examination (MSE), physical examination, laboratory tests

- Use of standardized depression checklists such as the Children's Depression Inventory (CDI) and the Beck Depression Inventory (BDI)
- Assessment of risk for suicidal behaviors
- Global functioning assessment using scales such as the Children's Global Assessment Scale or the Global Assessment of Functioning
- Identification of other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders)
- Ongoing assessment

Differential Diagnosis

Anxiety disorders	Chronic fatigue syndrome
Learning disabilities	Bereavement
Disruptive disorders	Anorexia nervosa
ADHD	Premenstrual dysphoric disorder
Substance abuse	Bipolar disorder
Personality disorder	Eating disorders
Medical disorders	Domestic violence, sexual and physical abuse issues
Adjustment disorder	Sexual identity and orientation issues in adolescence

DSM-IV Criteria for Major Depressive Disorder

Major Depressive Disorder (MDD), in general consists of:

- One or more Major Depressive Episodes, as defined below,
- Not better accounted for by Schizoaffective Disorder, and not superimposed on Schizophrenia, Schizophreniform, Delusional, or Psychotic Disorder, **and**

There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode (except as may have been induced by substance, treatment, or due to the direct physiological effect of a general medical condition).

A Major Depressive Episode, as defined by the DSM-IV, consists of either a depressed or irritable mood and/or a loss of interest or pleasure for at least 2 weeks, in addition to the presentation of 5 or more of the following symptoms:

• DEPRESSED MOOD MOST OF THE DAY, NEARLY EVERY DAY	• PSYCHOMOTOR RETARDATION OR AGITATION
• MARKEDLY DIMINISHED INTEREST IN ACTIVITIES, MOST OF THE DAY, NEARLY EVERY DAY	• DECREASED ENERGY OR MOTIVATION
• SIGNIFICANT WEIGHT LOSS/WEIGHT GAIN	• GUILT FEELINGS
• INSOMNIA/HYPERSOMNIA	• INABILITY TO CONCENTRATE
	• RECURRENT THOUGHTS OF DEATH OR SUICIDAL IDEATION, SUICIDE ATTEMPT OR PLAN

AND these symptoms:

• SOCIAL IMPAIRMENT OR IMPAIRMENT IN PERFORMANCE OF ACTIVITIES • UNRELATED TO SUBSTANCE ABUSE	• UNRELATED TO BEREAVEMENT • UNRELATED TO MEDICATION USE OR OTHER PSYCHIATRIC ILLNESS

Treatment

Treatment Planning

- Develop treatment plan appropriate to developmental stage of child or adolescent
- Provide services in the least restrictive environment that provides safety and effectiveness

Acute Treatment

- The choice of initial therapy depends on
  - Chronicity
  - Severity and number of prior episodes
  - Contextual issues
  - Previous response to treatment
  - Age of service recipient
  - Compliance with treatment
  - Service recipient's and family's motivation for treatment
- Pharmacotherapy alone usually is not sufficient.
- The high degree of comorbidity and the severity of psychosocial and academic consequences of depression suggest a multi-modal treatment approach.
- Because depression usually runs in families it is important to assess and treat other family members and those who live with the service recipient.

Service recipient and Family Education

The service recipient and caregivers should be taught about the disease and the treatment involved. Family education involves family members as informed partners in the treatment team, and helps them understand depression as an illness, identify and manage affect, address psychosocial deficits, and learn the importance of compliance with treatment. Participation by parents may help them identify their own depressive symptoms.

Psychotherapy

- *Cognitive-Behavioral Therapy (CBT)* is based on the premise that depressed service recipients have cognitive distortions in how they view themselves, the world, and the future; that these cognitive distortions contribute to their depression. CBT teaches service recipients to identify and counteract these distortions. Clinical studies found a high rate of relapse upon follow-up, suggesting the need for continuation treatment.

- *Interpersonal Therapy (IPT)* focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and personal difficulties. IPT has been shown to be useful in the acute treatment of adolescents with MDD. The rate of relapse may be relatively low after acute IPT treatment.
- *Psychodynamic psychotherapy* can help youth understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behavior, interact more effectively with others, and cope with ongoing and past conflicts.
- *Family Therapy* may be indicated where there is a history of substance abuse in the family, or domestic abuse, divorce, or similar stressors. Because depression usually runs in families it is also important to assess and treat other family members and those who live with the service recipient.
- *Group Therapy* may be indicated for adolescents and older children.
- *Expressive Therapy* (i.e. play, art, writing) is recommended by many clinicians to facilitate a child's ability to identify and process difficult feelings and issues.

Antidepressant Medication

Pharmacotherapy alone is never sufficient as the sole treatment. Combined treatment promotes self-esteem, coping skills, adaptive strategies, and improved peer and family relationships.

Antidepressant medications seem indicated for children and adolescents with severe symptoms that prevent effective psychotherapy; whose symptoms fail to respond to an adequate trial of psychotherapy; with chronic or recurrent depression; and with psychotic or bipolar depressions.

Prior to initiating treatment, specific target symptoms should be defined with the service recipient and parents. They should be informed about side effects, dose schedule, the lag in onset of therapeutic effect, and the danger of overdose. Parents should maintain responsibility for storing and administering the medications to enhance compliance and minimize suicidal risk from overdose. Quantity of dispensed medications should be monitored carefully.

Selective serotonin reuptake inhibitors (SSRIs) are the initial antidepressants of choice for service recipients requiring pharmacotherapy, although the presence of comorbidities may require alternate initial agents or a combination of medications. There is no indication for laboratory tests before or during the administration of SSRIs.

SSRIs are the drugs of choice because of their safety, side effect profile, ease of use, and suitability for long-term maintenance. Since improvement with the SSRIs may take 4 to 6 weeks, service recipients should be treated with adequate and tolerable doses for at least 4 weeks. At 4 weeks, if service recipients have not shown even minimal improvement, treatment should be modified (e.g., increase dose, change medications). If the service recipient shows improvement at 4 weeks, the dose should be continued for at least 6 weeks. The SSRIs have a relatively flat dose-response curve, suggesting that maximal clinical response may be achieved at minimum effective doses.

Tricyclic Antidepressants are not recommended as first line treatment for youth with depressive disorders because of the lack of efficacy and potential side effects. Nevertheless, individual service recipients may respond better to the Tricyclic Antidepressants (TCAs) than other medications. If TCAs are used, baseline electrocardiogram (EKG), resting blood pressure and pulse (supine or sitting, standing), and weight should be monitored regularly.

Augmentation agents may be indicated for children who are resistant to treatment or present complicating factors. Such agents may include:

- Trazodone
- Anticonvulsants
- Antimania medication
- ECT (only as authorized by statute. See T.C.A. 33-8-301 et seq.)
- Antipsychotic medication (for MDD with psychotic features)*

  * See guideline on treatment of Schizophrenia for additional information on antipsychotic medication

Continuation Phase

- Continuation therapy is recommended for all service recipients for at least 6 months after remission.
- The service recipient and his or her family should be taught to recognize early signs of relapse.
- Continuation psychotherapy helps to foster medication compliance.
- Antidepressants must be continued at the same dose used to attain remission of acute symptoms.
- At the end of the continuation phase, for service recipients who do not require maintenance treatment, medications should be discontinued gradually.

Maintenance Therapy

Clinicians should consider maintenance therapy for service recipients with multiple or severe episodes of depression and those at high risk for recurrence. Factors associated with recurrence include a family history of bipolar disorder or recurrent depression, comorbid psychiatric disorders, stressful or non-supportive environments, and residual or subsyndromal symptomatology.

The treatments that were used to induce remission in the acute phase should be used for maintenance therapy. Youth with two or more episodes of depression should receive maintenance treatment for at least 1 to 3 years. Service recipients with recurrent episodes accompanied by psychosis, severe impairment, severe suicidality, and treatment-resistance, as well as service recipients with more than 3 episodes, should be considered for longer, even lifelong treatment.

The long-term effects of antidepressants on maturation and development of children have not been studied. The clinician and service recipient's family should therefore weigh the risks and benefits of pharmacotherapy in maintenance therapy.

DYSTHYMIC DISORDER

DSM-IV Criteria for Dysthymic Disorder (child or adolescent)

- Depressed Mood, most of the day, more days than not, for at least one year
- Presence, while depressed, of two or more of the following
  - ♦ poor appetite or overeating
  - ♦ low energy or fatigue
  - ♦ low self-esteem
  - ♦ poor concentration or difficulty making decisions
  - ♦ feelings of hopelessness

- The foregoing symptoms have not abated for more than 2 months at a time during the year.
- The disturbance is not better accounted for by MDD.
- There has never been a manic, mixed, or hypomanic episode.
- The disturbance does not occur exclusively in the course of a Psychotic Disorder.
- The symptoms are not due to physiological effects of substance use or a general medical condition.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Treatment

Clinical practice and theory support the use of psychotherapies of varying degrees of intensity to treat Dysthymic Disorder (DD). In the absence of published studies of psychotherapeutic or pharmacologic treatment of children and adolescents with DD or comorbid MDD and DD, clinicians are advised to use interventions recommended for the treatment of youth with MDD.

PREVENTION

Youth with subclinical depressive symptoms are at high risk to develop clinical depression. When these symptoms persist after an episode of depression, continuous treatment until full remission is recommended. For service recipients who have not had an episode of depression, psychosocial interventions to reduce environmental and family stressors and CBT strategies appear to be efficacious to prevent deterioration.

Children with DD usually have a first episode of MDD 2 to 3 years after the onset of the DD, suggesting that DD is a gateway to recurrent mood disorders and indicating the need for early intervention with mild to moderate depression. Early intervention with depressed youth also may avert the development of comorbid psychiatric disorders. For example, MDD often precedes the onset of substance use disorders and treatment of depression may prevent their development.

TDMHDD Guideline

Mental Retardation and Comorbid Disorders In Persons Under 22 Years of Age

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have mental disorders comorbid with mental retardation (MR). These guidelines are adapted from the following sources:

Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 Dec;38(12 Suppl):5S-31S [117 references]

Rush AJ, & Frances A,. eds. *The Expert Consensus Guideline Series: Treatment of Psychiatric and Behavioral Problems in Mental Retardation.* American Journal on Mental Retardation 2000;105:159-228.

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to twenty-one to twenty-two years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.

2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment and Diagnosis

Overview

Psychiatric and behavioral assessment of persons with MR includes:

- Comprehensive assessment of MR
- Assessment of mental illness in persons with mental retardation, including comprehensive history, service recipient interview, medical review and diagnostic formulation.

Diagnosis of MR (Considerations, based on DSM-IV and AAMR criteria)

Criteria	Definition	
Significantly sub-average intellectual functioning	IQ approximately 70 or below	
Below average IQ causes limitations in adaptive skills* and functioning in at least two of the following areas:	Communication, Self-direction, Self-care, Functional academic skills, Home living, Work, Social/interpersonal skills, Leisure, Use of community resources, Health and safety	
Age at onset	Must be evident before age 18	
Levels of serverity (DSM-IV)	Mild Moderate Severe Profound Unspecified	IQ 55-70 IQ 40-55 IQ 25-40 IQ below 25 Strong presumption, but the individual's intelligence is untestable by standard instrument
Levels of supports needed (AAMR)	Intermittent, Limited, Extensive, or Pervasive	
Be cautious in interpreting low IQ in the presence of a psychiatric disorder	Impairment in IQ must precede and not be directly related to psychiatric disorder	

** as identified from, e.g., the Vineland Adaptive Scales*

Assessment of Mental Illness in Persons with MR

Mental illness is frequently comorbid with mental retardation, with most prevalence estimates ranging from 30% to 70%. Virtually all categories of mental disorders have been reported in this population.

However so, diagnostic precision, in the presence of MR, is not always feasible. There is strong consensus opinion that specific psychiatric diagnosis is not routinely and reliably possible in more severe cases of MR. Many practitioners use medication only when there is a specific psychiatric diagnosis.

The psychiatric diagnostic evaluation of persons who have MR is in principle the same as for persons who do not have mental retardation. The diagnostic approaches are modified, depending on the service recipient's cognitive level and especially communication skills. For persons who have mild MR and good verbal skills the approach does not differ much from diagnosing persons with average cognitive skills. The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the service recipient and on direct behavioral observations.

Assessment Methods

Preferred methods of evaluation

Interview with family/caregivers	Direct observation of behavior
Medical history and physical examination	Functional behavioral assessment
Medication and side effects evaluation	Unstructured psychiatric diagnostic interview †

Also consider:

- Standardized rating scales (e.g. SCID, BDI)
- Biomedical evaluation, including family, pregnancy, perinatal, developmental, health, social, and educational history; physical and neurodevelopmental examination; and laboratory tests. Laboratory tests are usually indicated by the findings in the history and physical examination and may include chromosomal analysis (including fragile-X by DNA analysis); brain imaging (CT scan, MRI); EEG; urinary amino-acids; blood organic acids and lead level; appropriate biochemical tests for inborn errors of metabolism.
- Standardized testing (e.g. intelligence, neuropsychological, language) ††

† *first line for mild/moderate MR, but not severe/profound MR*

†† *in mild/moderate MR Only*

Recipient and Caregiver Interview

The recipient may present communication deficits or may otherwise be shy in regard to disclosure of relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the recipient lacks adequate communication skills. Attempts should be made to collect both anecdotal subjective information and more objective data, such as the Vineland Adaptive Scales, daily record keeping, or graphical data.

Comprehensive History Includes:

- Presenting symptoms/behaviors
- Assessment of functioning
- Treatment history
- Placements and supports
- Family/household dynamics
- Past evaluations

Recipient Interview:

- Ample time should be allotted for the service recipient interview. Sufficient time is needed to put the service recipient at ease.
- The interview should be adapted to the service recipient's communication skills.
- Clear and concrete language should be used.
- Reassurance and support should be provided.
- Leading and yes/no questions should be avoided.
- The interviewer should attempt to ensure that questions are understood.
- Mental status may be assessed from context of conversation, rather than by formal examination.
- Nonverbal expression and activity should be considered.

Medical Review

- Developmental history
- Medical history
- General medical disorders and treatments

Evaluation of Stressors

Complete evaluation and individualized treatment requires attention to possible stressors that may be triggering or exacerbating the presenting problem in someone with MR. The stressors listed below may be more likley to occur in persons with MR, and cause difficulties for those who have reduced coping skills. Helping the individual, family, and caregivers deal with or eliminate stressors may sometimes be the primary target of treatment and often facilitates whatever other treatment interventions are necessary.

Type of Stressor	Examples
Change	Moving, new school or job, change of routine, developmental milestones, *transition from developmental centers*
Interpersonal	Loss of significant other, displacement from job or school
Environmental	Crowding, noise, disorder, lack of stimulation, lack of privacy, work or school-related pressure
Parenting/Social Support	Lack of support from others; disruptive visits/contacts; neglect, hostility, physical or sexual abuse
Illness/Disability	Chronic illness, serious acute illness, sensory deficits, difficulty with ambulation, seizures
Stigmatization problems	Being taunted, teased, excluded, bullied, or exploited
Frustration	Inability to communicate needs & wishes; lack of choice in living & work situations; self-awareness of deficits
Trauma	*Persons with mental retardation have higher rates of victimization*

Treatment

Generally

The habilitation of persons with MR is based on the principles of normalization and community based care, with additional supports as needed. Federal legislation, for example, the Individuals with Disabilities Education Act (IDEA), entitles disabled children and adolescents to a full range of diagnostic, educational and support services from birth to age 21. Specialized treatments are also provided if necessary, as is done for persons with severe visual and auditory impairment.

The parents of children and adolescents with MR are entitled by these laws to receive support services and to be active participants in treatment planning. Some parents and older service recipients are not aware of their rights to obtain services. The clinician has an important role in such instances to educate and, if needed, to refer to a "patient advocate" or "educational advocate."

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with MR are now rarely if ever placed in residential institutions and separate schools. Adults with MR of all levels live in the community, in settings varying from their own apartments with supports as needed, to small shared living situations. They are employed in specialized settings or, increasingly, in the competitive job market. Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in MR (e.g., shunting in the case of hydrocephalus).
- Early intervention, education, and ancillary therapies (such as physical, occupational, language therapies, ***and behavior therapies***), family support, and other services, as needed.
- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome, treatment of seizures in persons with tuberous sclerosis, etc.
- Psychiatric treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric Treatment

The approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Modifications of treatment may be necessary, according to the individual's circumstance. Persons with Down Syndrome, e.g., may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents.

Medical, habilitative, and educational interventions should be coordinated within an overall treatment program. Medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and general medical treatment.

Medication decisions should be appropriate to the diagnosis of record, based upon specific indications, and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective.

Medication decisions need to be based upon adequate information, including medication history and consideration of the individual's complete, current regimen. Medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive function or exacerbation of ataxia. Risk vs. benefit needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

Behavioral Emergencies

- Restraint of any kind, where permitted, is used only when efforts at redirection have failed and the service recipient poses an imminent risk of harm to self or others.
- Emergency medications, where permitted, are given only after appropriate diagnostic assessment and other alternatives are contraindicated.
- Possible medical causes for an acute behavioral exacerbation must be considered (e.g., other illness, injury, medication side effects).
- Reassessment of the diagnosis and the plan of treatment and support are indicated when there is an emergent behavioral episode.

Psychotherapeutic Interventions

Psychotherapy can be effective for persons with MR, toward realization of a variety of goals such as:

- Mitigation of stressors
- Improved coping skills
- Improved communication of feelings, problems, etc.
- Improved problem solving skills
- Improved social and interpersonal skills
- Reduction/elimination of maladaptive behaviors
- Increase of adaptive behaviors
- Understanding of disability and illness
- Increased self-esteem

Modality and Technique

Group, individual, or family psychotherapy may be appropriate for persons with MR. As with psychiatric care, the approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Techniques typically utilized with persons with mental illness can be considered potential interventions for persons who are dually diagnosed, with adaptations made as necessary, based on the needs and strengths of the individual. The approach to therapy may need to be more concrete, repetitive, and/or directive, and may need to incorporate visual and auditory aids. Role play can be effective, and behavior modification techniques, such as positive reinforcement are very important.

Generally, the lower the cognitive and adaptive functioning of the person(s), the more extensive the modifications which will need to be made in technique. Some techniques are rarely appropriate for persons who function at the lower levels of mental retardation.

Group therapy, in particular, can be an invaluable treatment approach for a wide range of emotional, behavioral and life problems. Group therapy uses the power of group dynamics and peer interaction to promote learning and development of new skills among individual group members. Group therapy can be used in promoting skills in decision making, problem solving, expression of feelings, socialization, communication, and in maintaining behavioral change.

Family therapy typically focuses on the parents' identification and support of their child's strengths and independence, and the provision of opportunities for success. Parents of recently diagnosed children need careful explanation of their child's condition. Concrete advice in management and resource finding is

important, as well as help in obtaining educational supports to which the child is entitled under federal and local laws. Parents of adolescents and young adults need help in coming to terms with emergent sexuality, and in emotionally separating and preparing them to move to out-of-family living in the community.

Behavior Therapy is based upon scientific principles of behavior and uses a functional assessment to understand the variables that influence the behavior. Generally, to be effective, behavior therapy should be applied in all settings, and include an emphasis on increasing functional replacement skills, along with the reduction of the maladaptive behavior. This approach may include adjusting the environment to reduce physical and social conditions that seem to trigger maladaptive behaviors, and various specific techniques, such as systematic desensitization, progressive relaxation, anger management, assertiveness training, and training more effective social and interactional skills.

Conjoint Therapy with or without the child present may be used to address specific behavioral issues, and allows parents or caregivers to report their observations frankly. Parents or caregivers can be supported in their efforts at behavior management, which may otherwise tend to be transitory.

Treatment Follow-up

A common problem in the treatment of persons with MR is assessing its effectiveness, which may be viewed differently by various caregivers. Therefore, discrete treatment goals should be agreed upon by the clinician and caregivers, as well as target or "index" symptoms. Interdisciplinary collaboration of professionals and caregivers is essential. Various mental health clinicians might function in the team as direct care providers, team leaders, or consultants to other professionals. Among them, clinicians with medically and psychologically oriented training are often prepared to function as synthesizers of treatment modalities of various disciplines. Followup includes service recipient interview/observation and obtaining comprehensive interim information. If the service recipient is not experiencing improvement, the accuracy and completeness of the biopsychosocial diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

TDMHDD Guideline

Posttraumatic Stress Disorder (PTSD) in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have posttraumatic stress disorder. These guidelines are adapted from the following sources:

> *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorders*. J. Am. Acad. Child Adolsec. Psychiatry, 37:10 Supplement, October 1998
>
> Foa EB, Davidson JRT, and Frances A, eds. *The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder*. J Clin Psychiatry 1999;60 (Suppl 16).

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

A. To improve the quality and appropriateness of care for children/adolescents who are diagnosed as having posttraumatic stress syndrome.

B. To aid practitioners in the difficult task of assessment and in choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgment, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment and Diagnosis

In order to accurately assess and diagnose a child or adolescent with Posttraumatic Stress Syndrome, the following information must be obtained and analyzed.

Interview parent or primary caregiver. (Note: If a parent is the alleged perpetrator of child abuse or domestic violence that is the identified traumatic event, the non-offending parent or other primary caretaker should be interviewed. Interview of the alleged perpetrator is not required to diagnose and treat PTSD in the child.)

Conduct careful and direct interview with the child/adolescent, using developmentally appropriate language.

Obtain report of the traumatic event(s). (Note the nature of the event, when it occurred, the parents' perception of the child's degree of exposure to the event. The parent(s) and the child both should be asked directly about the traumatic events and PTSD symptoms in detail).

Determine whether the event qualifies as an "extreme" stressor:

- The stressor must be extreme, not just severe. The event involved actual or threatened death, serious injury, rape, or childhood sexual or physical abuse. Many frequently encountered stressors that are severe but not extreme would not be included (e.g., losing a job, divorce, failing in school, expected death of a loved one).

- The stressor causes powerful subjective responses: The person experienced intense fear, helplessness, or horror.

Obtain report of any preceding, concurrent or more recent stressors in the child's life.

Stressors that may contribute to PTSD

Significant conflict, separation, or divorce	Frequent moves, school changes, or other significant disruptions
Serious accident	Child sexual abuse
Natural disaster	Child physical abuse or severe neglect
Criminal assault	Hostage/imprisonment/torture
Witnessing or learning of traumatic events	Family deaths, illnesses, disabilities, or substance abuse.

Obtain report of DSM-IV PTSD symptomatology in the child, with particular attention to developmental variations in clinical presentation.

Key symptoms Examples:

Reexperiencing the traumatic event	• Intrusive, distressing recollections of the event • Flashbacks (feeling as if the event were recurring while awake) • Nightmares (the event or other frightening images recur frequently in dreams) • Exaggerated emotional and physical reactions to triggers that remind the person of the event
Avoidance	• Of activities, places, thoughts, feelings, or conversations related to the trauma
Emotional numbing	• Loss of interest • Feeling detached from others • Restricted emotions
Increased arousal	• Difficulty sleeping • Irritability or outbursts of anger • Difficulty concentrating • Hypervigilance • Exaggerated startle response

Obtain report of any other significant current symptomatology. Give particular attention to disorders with high comorbidity with PTSD. (See Differential Diagnoses, below.)

Obtain report of whether the symptoms began prior to or following the identified traumatic event(s). (Note: This determination may be difficult if the stressor has been longstanding or ongoing; e.g., physical abuse).

Obtain report of the parents' and other significant others' emotional reaction to the traumatic event.

- Ascertain whether the parent or primary caregiver was directly exposed to the trauma (e.g., driving when a motor vehicle accident occurred) or experienced only vicarious exposure (e.g., child disclosed sexual abuse by a stranger)
- Obtain report of the presence of parental PTSD symptoms following the traumatic event
- Obtain perception of how much support has been available to the child since the event

Obtain report of child's past psychiatric history, including:

- Outpatient psychotherapy
- Partial or inpatient hospitalization
- Psychotropic medications
- Symptom course

Obtain medical history, including:

- Significant current or past medical problems, somatic complaints, surgery, significant injuries
- Current or past medications
- Current primary medical care provider

Obtain report of child's developmental history, with particular emphasis on reactions to normal stressors (e.g., birth of sibling, beginning school) and child's level of functioning prior to the traumatic stressor.

Obtain report of school history, with particular emphasis on changes in school behavior, concentration, activity level, and performance since the traumatic stressor.

Obtain report of family history and family members' medical/psychiatric history, including:

- PTSD symptoms or diagnosis
- Mood disorders
- Anxiety disorders
- Family medical conditions including any that may present as anxiety or mood disorders (e.g., thyroid disease)

Conduct interview with the child, including mental status exam

- Obtain child's report of the reason for referral

- Encourage child to describe his or her memories of the traumatic event. (Note: There is no consensus regarding the optimal degree of detail, or whether certain kinds of leading questions are helpful or harmful. Clinical consensus clearly indicates that requesting some description of the stressor from the child is desirable but that the use of highly suggestive questioning is not recommended.)

- Obtain the child's report of trauma-related attributions and perceptions about the stressor(s), including:
  - → *Who or what the child believes was responsible for the traumatic event.*
  - → *Whether the child believes he or she had any responsibility for causing or perpetuating the traumatic event.*
  - → *Whether the child believes he or she should have behaved differently in response to the event.*
  - → *Whether the child feels ostracized, damaged, or negatively judged by others as a result of being exposed to the stressor.*
  - → *The child's perception of how emotionally distressed and supportive parents and significant others have been since the traumatic event.*
  - → *In cases where the stressor was not public knowledge, child's perception of whether adults believed his or her disclosure of exposure to the traumatic event.*
  - → *The child's perception of how "normal" his or her current symptoms are in reaction to the stressor.*

- Obtain child's report of present symptomatology, with particular emphasis on developmentally appropriate questioning regarding DSM-IV PTSD criteria symptoms. (Note: Although it is important for the evaluator to explore with the child the link between the traumatic event and PTSD symptomatology, many children may not make this connection. This should not deter the evaluator from diagnosing PTSD if the temporal relationship between the event and symptom formation as reported by child or parent supports this diagnosis.)

- Obtain child's report of symptomatology frequently associated with PTSD.
  - → *Depressive symptoms, including suicidal ideation.*
  - → *Substance abuse or self-injurious behavior (in older children and adolescents).*
  - → *Dissociative symptoms, including fugue states, periods of amnesia, depersonalization or derealization (in older children and adolescents).*
  - → *Panic attacks and other non-PTSD anxiety symptoms.*

- Observe the child for the elements of the mental status exam and for behaviors that are found with PTSD.
  - → *Increased startle reaction or vigilance*
  - → *Traumatic reenactment (in younger children)*
  - → *Observable changes in affect or attention that may be indicative of reexperiencing phenomena*

Obtain information from school with appropriate release of information, if clinically indicated. (Note: Although school reports may be helpful with regard to confirming certain symptoms or posttraumatic changes, in many cases, school reports are not necessary to diagnose or treat PTSD in children.) Information obtained should include:

- Academic functioning with particular attention to changes since the traumatic event.
- Interactions with peers and involvement in non-academic activities, with particular attention to changes since the traumatic event.
- Temporal appearance of ADHD symptoms (i.e., present prior to or only after the traumatic event).

Determine the need for additional evaluations. (IQ testing, speech and language evaluation, pediatric evaluation), as needed and make appropriate referrals.

Consider the usefulness of standardized interviews and rating scales. Although semistructured interviews and parent- and child-rating scales of PTSD symptomatology may be helpful in following the clinical course of children with PTSD, the diagnosis of PTSD is based primarily upon the clinical interview. The use of standardized interviews and scales is not necessary to make this diagnosis.

- Semistructured interviews. The following semistructured interviews include PTSD sections; none has established psychometric properties for measuring DSM-IV PTSD symptoms in children:

K-SADS-PL	Diagnostic Interview Schedule
Structured Clinical Interview for DSM-IV	Clinician-Administered PTSD Scale for Children and Adolescents.

- Child- and parent-rating forms that may be clinically useful for following the course of PTSD symptoms in children:

PTSD Reaction Index	Trauma Symptom Checklist for Children
Checklist of Child Distress Symptoms Child and Parent Report Versions	Children's Impact of Traumatic Events Scale
Child PTSD Symptom Scale	Impact of Events Scale (Revised version for adolescents)

Differential diagnosis:

Psychiatric disorders that may be comorbid with or misdiagnosed as PTSD, or which PTSD may be misdiagnosed as.

Acute stress disorder	Adjustment disorders
Panic disorder (frequently comorbid)	Generalized anxiety disorder (frequently comorbid)
Major Depression (frequently comorbid)	ADHD
Substance use disorders (frequently comorbid)	Dissociative disorders
Conduct disorder	Borderline or other personality disorder
Schizophrenia or other psychotic disorder	Malingering
Factitious disorder	Obsessive-compulsive disorder (frequently comorbid)
Bipolar Disorder (frequently comorbid)	Social phobia (frequently comorbid)

Establish the subtype of PTSD present.

- Acute
- Chronic
- With delayed onset

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing PTSD.
1–3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders.

Psychological and Psychiatric Treatment

Formulate the treatment plan based on the clinical presentation of the child and to address both PTSD symptoms and other behavioral and emotional problems the child is experiencing.

The course of PTSD and its particular symptom pattern in different children is extremely variable. Short-term, long-term, or intermittent treatment may be required. Different levels of care (outpatient, partial or inpatient hospitalization) and modalities (individual, family, group, psychopharmacologic therapy) may be required for different children or for a given child at different points in the course of the disorder. Comprehensive treatment for PTSD is generally multimodal and may include any or all of the following components.

Treatment Strategies Include:

Psychoeducation Education of the child, parents, teachers, and/or significant others regarding the symptoms, clinical course, treatment options, and prognosis of childhood PTSD.

Individual therapy

- Trauma-focused therapy should include:
  - → Exploration and open discussion of the traumatic event; relaxation, desensitization/exposure techniques may be useful.
  - → Examination and correction of cognitive distortions in attributions about the traumatic event.
  - → Behavioral interventions to address inappropriate traumatic reenactment (e.g., sexually inappropriate behaviors following sexual abuse; self-injurious, aggressive, and other behavioral difficulties).
  - → Cognitive-behavioral techniques to help child gain control over intrusive reexperiencing symptoms.
- Insight-oriented, interpersonal, and psychodynamic therapeutic interventions may be appropriate for treating PTSD in some children.
- Therapy to address non-PTSD behavioral and emotional difficulties, in conjunction with trauma-focused interventions.

Family Therapy

Trauma-focused parental therapy should include:

- → Exploration and resolution of the emotional impact of the traumatic event on the parent.
- → Identification and correction of inaccurate parental attributions regarding the traumatic event (e.g., self-blame, blaming the child).
- → Identification and implementation of appropriate supportive parenting behaviors and parental reinforcement of therapeutic interventions (e.g., teaching parents to help the child use progressive relaxation techniques).
- → Parent training on management of inappropriate child behaviors.

- Traditional family therapy with all immediate family members for families with high conflict, harsh discipline, and/or when PTSD symptoms are present in several family members. However, family therapy generally should occur only after the child has

received individual intervention to optimize comfortable disclosure of traumatic experiences and trauma-related symptoms. No empirical or clinical consensus is currently available regarding the use of family therapy for children with PTSD.

Group Therapy

- Trauma-focused groups for children of similar developmental levels who have experienced similar traumatic exposure may be beneficial in encouraging open discussion of and appropriate attributions regarding the event.
- School-based group crisis intervention may be particularly useful in disaster situations.
- Adult psychoeducational groups may be helpful in addressing parental and/or teacher concerns following exposure of groups of children to disaster or community violence situations.

Psychopharmacology

- Antidepressants (SSRIs, tricyclic antidepressants) may be useful for children exhibiting concurrent major depressive or panic disorder symptoms.
- Psychostimulants or alpha-adrenergic agonists (e.g., clonidine) may be useful for children exhibiting concurrent ADHD symptoms.
- Antianxiety medications (benzodiazepines, propranolol) generally have not been used to treat children with PTSD. There is no current clinical consensus that use of these medications is effective for this population.

Sequencing Treatments: Whether to Start with Psychotherapy, Medication, or a Combination of Both:

This guideline provides information on the sequencing of psychotherapy and medication in the treatment of PTSD. The same questions were asked of two separate groups: psychotherapy experts and medication experts. Both groups recommended psychotherapy as a first line treatment for PTSD, but the medication experts were much more likely to combine medication with psychotherapy from the start, especially for those service recipients with more severe or chronic problems.

Age	Severity	Acute PTSD	Chronic PTSD
In children and younger adolescents	Milder	Psychotherapy first	Psychotherapy first
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*
In older adolescents	Milder	Psychotherapy first	Psychotherapy first† *or* Combination of medication and psychotherapy†
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*

*On this question, psychosocial experts preferred psychotherapy first, whereas the medication experts preferred combination treatment.

†On this question, medication experts rated both psychotherapy and combined treatment first line, while the psychosocial experts preferred psychotherapy first.

Sequencing Treatments when PTSD Presents with Psychiatric Comorbidity:

When a comorbid psychiatric disorder is present, the experts recommend treating PTSD with a combination of both psychotherapy and medication from the start. It is therefore vital that questions about comorbidity and substance use should be included in the evaluation of every service recipient with PTSD.

Comorbid condition	Recommended strategy
Depressive disorder	Combine psychotherapy and medication from the start
Bipolar disorder	Combine psychotherapy and medication from the start
Other anxiety disorders (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	Combine psychotherapy and medication from the start
Substance abuse or dependence	
Milder problems with substance abuse	Provide treatment for both substance abuse and PTSD simultaneously
More severe problems with substance	Treat substance abuse problems first *or* Provide treatment for both substance abuse and PTSD simultaneously

Level of Care During the Initial Phase of Treatment (First 3 Months or Until Stabilized):

During the initial stage of treatment, the experts recommend that psychotherapy should generally be delivered weekly in individual sessions of about 60 minutes duration. Weekly medication visits are recommended for the first month, with visits every other week thereafter. Recommendations for treatment intensity during the maintenance phase are given in Guideline 8. *(**bold italics** =* treatment of choice)

	Recommended	Also consider
Frequency of psychotherapy sessions	Weekly	Twice a week
Duration of psychotherapy sessions	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions	***Individual***	Combination of individual and group or family therapy
Frequency of medication visits	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

Selecting the Initial Psychotherapy

Brief Descriptions of the Most Recommended Psychotherapy Techniques

Anxiety management (stress inoculation training): teaching a set of skills that will help service recipients cope with stress: Relaxation training: teaching the person to control fear and anxiety through the systematic relaxation of the major muscle groups. Breathing retraining: teaching slow, abdominal breathing to help the person relax and/or avoid hyperventilation with its unpleasant and often frightening physical sensations. Positive thinking and self-talk: Teaching the person how to replace negative thoughts (e.g., "I'm going to lose control") with positive thoughts (e.g., "I did it before and I can do it again") when anticipating or confronting stressors. Assertiveness training: teaching the person how to express wishes, opinions, and emotions appropriately and without alienating others. Thought stopping: distraction techniques to overcome distressing thoughts by inwardly "shouting stop."
Cognitive therapy: helping to modify unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning. For example, trauma victims often have unrealistic guilt related to the trauma: a rape victim may blame herself for the rape; a war veteran may feel it was his fault that his best friend was killed. The goal of cognitive therapy is to teach people to identify their own particular dysfunctional cognitions, weigh the evidence for and against them, and adopt more realistic thoughts that will generate more balanced emotions.
Exposure therapy: helping the person to confront specific situations, people, objects, memories, or emotions that have become associated with the stressor and now evoke an unrealistically intense fear. This can be done in two ways: **Imaginal exposure**: the repeated emotional recounting of the traumatic memories until they no longer evoke high levels of distress. **In vivo exposure**: confrontation with situations that are now safe, but which the person avoids because they have become associated with the trauma and trigger strong fear (e.g., driving a car again after being involved in an accident or using elevators again after being assaulted in an elevator). Repeated exposures help the person realize that the feared situation is no longer dangerous and that the fear will dissipate if the person remains in the situation long enough rather than escaping it. **Exposure therapy can be dangerous.** It needs to be gradual and supportive and well explained and consented to by the person and parents.
Play therapy: therapy for children employing games to allow the introduction of topics that cannot be effectively addressed more directly and to facilitate the exposure to, and the reprocessing of, the traumatic memories. With PTSD this therapy needs to be directive. Otherwise, children and teens tend to either avoid dealing with the triggers and symptoms of PTSD or can become frozen in the repetition of the trauma.
Psychoeducation: educating people and their families about the symptoms of PTSD and the various treatments that are available for it. Reassurance is given that PTSD symptoms are normal and expectable shortly after a trauma and can be overcome with time and treatment. Also includes education about the symptoms and treatment of any comorbid disorders.

Preferred Psychotherapy Techniques for Different Target Symptoms

Three psychotherapy techniques—exposure therapy, cognitive therapy, and anxiety management—are considered to be the most useful in the treatment of PTSD. As shown in the table below, the experts make distinctions among the techniques depending on which specific type of symptom presentation is most prominent. Psychoeducation is recommended as a high second line option for all types of target symptoms, probably reflecting the experts' belief that it is important in the treatment of every service recipient with PTSD, but is not by itself sufficient. Note also that the experts recommend considering play therapy for certain types of target symptoms in children.

Most prominent symptom	Recommended techniques	Also consider
Intrusive thoughts	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Flashbacks	Exposure therapy*	• Anxiety management • Cognitive therapy • Psychoeducation
Trauma-related fears, panic, and avoidance	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Numbing/detachment from others/loss of interest	Cognitive therapy	• Psychoeducation • Exposure therapy
Irritability/angry outbursts	Cognitive therapy Anxiety management	• Psychoeducation • Exposure therapy
Guilt/shame	Cognitive therapy*	• Psychoeducation • Play therapy for children
General anxiety (hyperarousal, hypervigilance, startle)	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation • Play therapy for children
Sleep disturbance	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation
Difficulty concentrating	Anxiety management	• Cognitive therapy • Psychoeducation

* Treatment of choice

Preferred Psychotherapy Techniques for PTSD with Comorbid Psychiatric Conditions

The type of comorbidity accompanying PTSD affects the choice of the specific psychotherapy techniques. The experts are especially likely to recommend cognitive therapy in the treatment of PTSD when there is a comorbid mood or anxiety disorder or a cluster B personality disorder. Anxiety management is especially recommended when a comorbid anxiety disorder is present or there are substance abuse problems. Exposure therapy is also especially recommended when there is a comorbid anxiety disorder.

Comorbid condition	Recommended techniques	Also consider
Depressive disorder	• Cognitive therapy*	• Exposure therapy • Psychoeducation • Anxiety management • Play therapy for children
Bipolar disorder	• Cognitive therapy*	• Psychoeducation • Anxiety management
Other anxiety disorder (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	• Anxiety management • Cognitive therapy • Exposure therapy	• Psychoeducation
Substance abuse or dependence	• Anxiety management	• Cognitive therapy • Psychoeducation
Severe cluster B personality disorder	• Cognitive therapy	• Anxiety management • Psychoeducation

* Treatment of choice

Selecting Psychotherapy Techniques Based on the Service Recipient's Age

To some extent, the choice of psychotherapy varies depending on the service recipient's age. Play therapy may be useful for children and younger adolescents. Exposure therapy is more strongly recommended for older adolescents than for children.

	Preferred techniques
For children and younger adolescents	Directive play therapy Psychoeducation Anxiety management Cognitive therapy
For older adolescents	Cognitive therapy* Exposure therapy* Anxiety management* Psychoeducation* Directive art therapy

* First-line treatment

Selecting the Next Step:

Experts contributing to the Consensus Guideline on PTSD were asked to recommend the next step when service recipients with PTSD have had no response to the initial treatment. Their first line recommendations were the same for service recipients with acute and chronic PTSD as well as for service recipients who also have suicidal or aggressive tendencies. For service recipients receiving monotherapy (i.e., medication alone or psychotherapy alone), the experts offered two general treatment recommendations:

1. Add the type of treatment the service recipient has not yet received (i.e., add medication to psychotherapy or add psychotherapy to medication) *and/or*
2. Switch to a different psychotherapy technique or to a different medication.

Both of these strategies may be helpful, either separately or in combination. Clinicians should use their clinical judgment, based on the specific situation, in deciding whether to add a new treatment, switch to a different treatment, or do both.

Presentation	No response to psychotherapy alone	No response to medication alone	No response to combined psychotherapy and medication
Acute and chronic PTSD	Add medication *and/or* Switch to other psychotherapy technique(s)	Add psychotherapy *and/or* Switch to another medication	Switch to another medication *and/or* Switch to or add other psychotherapy technique(s)

Strategies for Further Psychotherapy:

For a service recipient who is not responding to one of the three preferred psychotherapy techniques, the experts recommend adding one or both of the other two techniques. Adequate psychoeducation should also always be provided.

If current psychotherapy technique is	Combine with	Also consider
Anxiety management	• Cognitive therapy • Exposure therapy	• Psychoeducation
Cognitive therapy	• Anxiety management • Exposure therapy	• Psychoeducation
Exposure therapy	• Anxiety management • Cognitive therapy	• Psychoeducation

Treatment in Primary Care

Early Intervention and Prevention

What to do immediately after exposure to an extreme stressor or trauma:

- Help the service recipient understand that it is normal to be upset and have distressing symptoms shortly after a trauma.
- Provide education about acute stress reactions and PTSD.
- Encourage the service recipient to talk with family and friends about the trauma and experience the feelings associated with it.
- Educate family and significant others about the importance of listening and being tolerant of the person's emotional reactions.
- Help the service recipient and family accept the need for repeated retelling of the event in order to facilitate recovery. Provide emotional support.
- Relieve irrational guilt.
- Refer to peer support group or trauma counseling.
- Consider short-term sleep medication for insomnia.

Primary Treatment Selection

If symptoms have lasted for at least one month without significant improvement:

1. Offer or refer for psychological treatment

2. Also prescribe medication if:
   - Symptoms are severe and/or persistent.
   - Daily functioning is severely disrupted.
   - Service recipient has severe insomnia.
   - Service recipient has another psychiatric problem (e.g., depression, anxiety, suicidal thoughts).
   - Service recipient is experiencing a lot of stress.
   - Service recipient has already been receiving psychotherapy and is still having significant symptoms.

Recommended Psychological Treatments include:

- Anxiety Management
- Cognitive Therapy
- Exposure Therapy

When to Refer for Specialized Psychiatric Care

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are treating PTSD, the particular needs and preferences of the service recipient, and the availability of other services. However, referral for specialized care is often necessary in the following situations:

- Service recipient has persistent impairing PTSD symptoms that have not responded to at least one systematic medication trial, adequate in dose and duration.
- Service recipient has suicidal thoughts/behavior.
- Service recipient has had persistent problems with medication side effects.
- Service recipient has other serious psychiatric problems (e.g., depression, anxiety) that are not improving with treatment.
- Service recipient has substance abuse problems.
- Service recipient is experiencing other life stressors and/or has limited social support.

TDMHDD Guideline

Schizophrenia in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with schizophrenic symptoms in primary care and behavioral treatment settings. These guidelines are adapted from the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with schizophrenia.* J Am Acad Child Adolesc Psychiatry 1994 Jun;33(5):616-35 [90 references]
>
> *The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations*. 1998. Agency for Healthcare Quality and Research, Rockville, MD. http://www.ahrq.gov/clinic/schzrec.htm

The user may wish to refer to the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with schizophrenia and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Bipolar Disorder
Schizoaffective Disorders
Other Psychotic Disorders
Pervasive Developmental Disorders
Non-psychotic behavioral and/or emotional disorders
Organic Disorders

- delirium
- seizure
- CNS lesion
- neurodegenerative
- metabolic
- toxic encephalopathy
- infectious diseases

Developmental Language Disorders
Obsessive-Compulsive Disorder
Factitious Disorder
Substance abuse/Substance induced psychosis
Personality Disorder

- paranoid
- borderline
- schizotypal
- schizoid

DSM-IV Criteria

A. At least 2 of the following must be present for a significant period of time during a 1-month period:

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (flattened affect, paucity of thought or speech)

Only one symptom need be present if the delusions are bizarre; the hallucinations include a voice providing a running commentary on the person's behavior or thinkin; or 2 or more voices are conversing with each other.

B. In children and adolescents, there is failure to achieve expected level of interpersonal, academic, or occupational achievement.

C. The disturbances must be present for a period of at least 6 months, which period must include one month (less, if successfully treated) of active-phase symptoms described above, which may include residual or prodromal symptoms.

D. Schizoaffective Disorder and Mood Disorder with Psychotic Features are ruled out.

E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

F. Where there is a history of Autistic or other Pervasive Developmental Disorder, delusions or hallucinations are also present for at least one month (less, if successfully treated).

Evaluation

Complete diagnostic assessment including a neurologic and thorough psychiatric evaluation, school information, and history is needed, and specifically should include the following:

- Premorbid History (prenatal, developmental, personality, highest LOF)
- History of present illness (DSM-IV target symptoms; course of illness, including onset, cyclical patterns, precipitating stressors; associated or compounding symptoms, especially mood disturbances, substance abuse, and organic factors
- Physical evaluation
- Family history (environment, interactions, coping styles, resources, strengths; history of psychiatric and neurological conditions, and substance abuse)
- School functioning
- Suspected skills deficits

Rule out other disorders and determine if necessary to hospitalize.

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

Treatment Overview

Multimodal psychotherapeutic interventions include:

1) medication management
2) periodic diagnostic reassessments to ensure accuracy of diagnosis
3) appropriate psychotherapy
4) psychoeducational services for the service recipient
5) supportive services for the family
6) educational and vocational services
7) residential services when indicated

Medication Therapy

Acute phase

Before initiating antipsychotic therapy, a thorough psychiatric evaluation is needed, which should include documentation of the psychotic symptoms targeted for the therapy. Preexisting abnormal movements should also be noted. Informed consent is needed from the parent and adolescent service recipients, while consent, when possible, should be obtained from preadolescents.

The choice of antipsychotic medication should be made based on the agent's relative potency, spectrum of side effects, and history of medication response in the service recipient and his or her family. Side effects that may occur with all antipsychotics (except clozapine) include extrapyramidal symptoms, anticholinergic symptoms, withdrawal dyskinesia, tardive dyskinesia, and neuroleptic malignant syndrome. There are also side effects specific to a particular agent, such as lenticular stippling with thioridazine, that need to be monitored when the agent is used.

When using antipsychotics, antiparkinsonian agents may be needed for the treatment of extrapyramidal side effects. Prophylactic use of antiparkinsonian agents should be

considered in situations where extrapyramidal symptoms are likely, such as when using high-potency neuroleptics, when treating new service recipients, or when treating paranoid service recipients in whom a dystonic reaction may significantly impair compliance.

First-line drugs of choice include: **Olanzapine, Quetiapine, or Risperidone.** To determine whether or not antipsychotic medication is effective, it must be used for at least four to six weeks at adequate dosages. If no effects are seen at that point, consideration should be given to changing to a different class of antipsychotic medication.

Recovery phase

Once the acute psychotic symptoms are stabilized, the service recipient may still have ongoing difficulties with confusion, disorganization, motivation, and possible dysphoria. Antipsychotic medication should be maintained through this phase to prevent acute exacerbations. The goal of therapy is to reintegrate the service recipient back to his or her home and school, if possible.

Residual or remission phase

The service recipient should be maintained on the lowest effective dose of antipsychotic medication. Once the service recipient is clinically stable, the dosages should be reassessed approximately every 6 months. Many service recipients will be chronically impaired and need to be maintained on long-term antipsychotic agents.

When discontinuing these agents, they should be tapered, given the increased risk in children for withdrawal dyskinesia. The exception to this is when neuroleptic malignant syndrome occurs. Careful monitoring is needed during times in which the dosage is being changed to assess for symptoms of relapse.

Longitudinal medication management is needed to monitor side effects, including tardive dyskinesia.

Relapse of symptoms

When a service recipient relapses, it should first be determined whether or not the service recipient was compliant with his or her antipsychotic medications. If not, resumption of the medication should occur. The drugs of choice for non-compliant service recipients are Haloperidol Decanoate or Fluphenazine Decanoate because of the availability of a depot injection every 3 weeks. **Depot injections are not recommended for children and are only recommended for adolescents with documented chronic psychotic symptoms and a history of poor medication compliance.**

If the service recipient was compliant and had been previously responding and tolerating the agent, an increase in the medication dose may stabilize the psychotic symptoms (keeping in mind the standard dosage ranges).

If symptoms relapse and the service recipient is not adequately responding to the current antipsychotic agent (while being used at adequate dosages), a trial of a different neuroleptic should then be undertaken.

Service recipients who relapse may require acute hospitalization. This decision should be based on the severity of psychotic symptoms, potential danger to self or others, degree of

impairment in the service recipient's ability to maintain basic self-care, and the availability of supportive services in the community.

Service recipients who do not respond to antipsychotics

Before it is decided that the service recipient is a non-responder, the service recipient must receive at least two adequate trials of different antipsychotic agents.

In adults, there are reports of successfully augmenting antipsychotic therapy with lithium, anticonvulsants, benzodiazepines, and fluoxetine. However, these are yet unproven and have not been studied in children and adolescents.

There are reports of clozapine being used successfully for adolescents with schizophrenia, however, in the United States, there is little experience with its use in service recipients younger than sixteen years of age. If it is to be used, close monitoring for potential seizures, agranulocytosis (with periodic blood cell counts), and weight gain is necessary.

Adjunctive pharmacotherapies should be considered in service recipients who experience persistent and clinically significant associated symptoms of anxiety, depression, or hostility, despite an adequate reduction in positive symptoms with antipsychotic therapy.

Other Treatment Modalities to be Considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with schizophrenia, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least 9 months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- **for the service recipient**, includes cognitive-behavioral strategies, such as social skills and problem-solving skills, and ongoing education about the illness, medication effects, and basic life skills training

- **for the family** promotes understanding of the illness, treatment options, and prognosis and development of strategies to cope with the symptoms of the service recipient

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's schizophrenic disorder *should not* be used)

Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality

Partial hospitalization or day treatment programs

Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings

Residential treatment

Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting. Less restrictive alternatives must have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Psychosocial Rehabilitation

Effective treatment may require a flexible array of services and supports, including case management, in-home services, family support, and school-based services. Supports and services of this kind are individualized and are designed to ameliorate the physical, mental, cognitive or developmental effects of schizophrenia.

Systems of care serving persons with schizophrenia who are high service users should include assertive case management and assertive community treatment programs. These programs should be targeted to individuals at high risk for repeated rehospitalizations or who have been difficult to retain in active treatment with more traditional types of services.

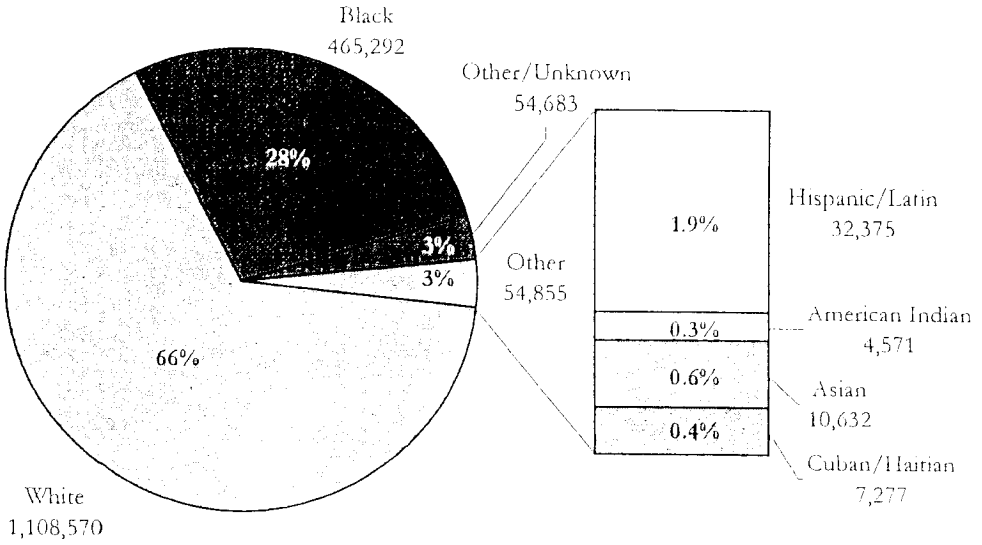
PROGRESS REPORT

ON THE TENNCARE PARTNERS PROGRAM: CHILDREN & YOUTH, FISCAL YEAR 2002

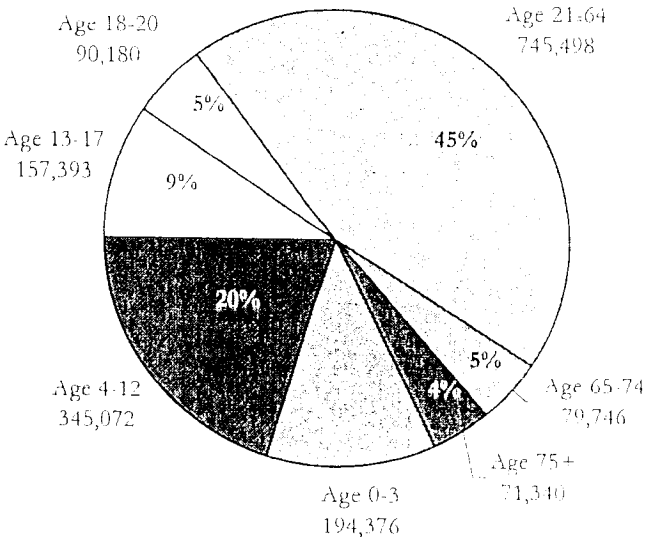
State of Tennessee
Bureau of TennCare and
Department of Mental Health and Developmental Disabilities
Office of Managed Care
Cordell Hull Building - 5th Floor
Nashville, TN 37243

Profile of Total TennCare Eligibles: FY 2002 (N=1,683,609)*

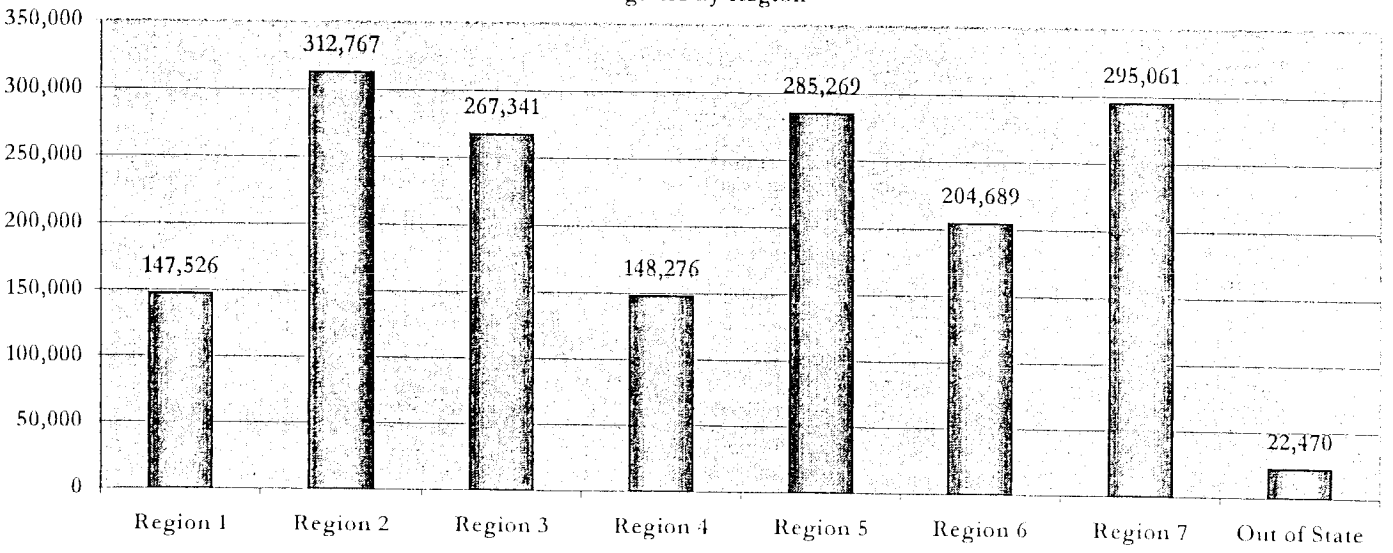
Eligibles by Race



Eligibles by Age Group



Eligibles by Region



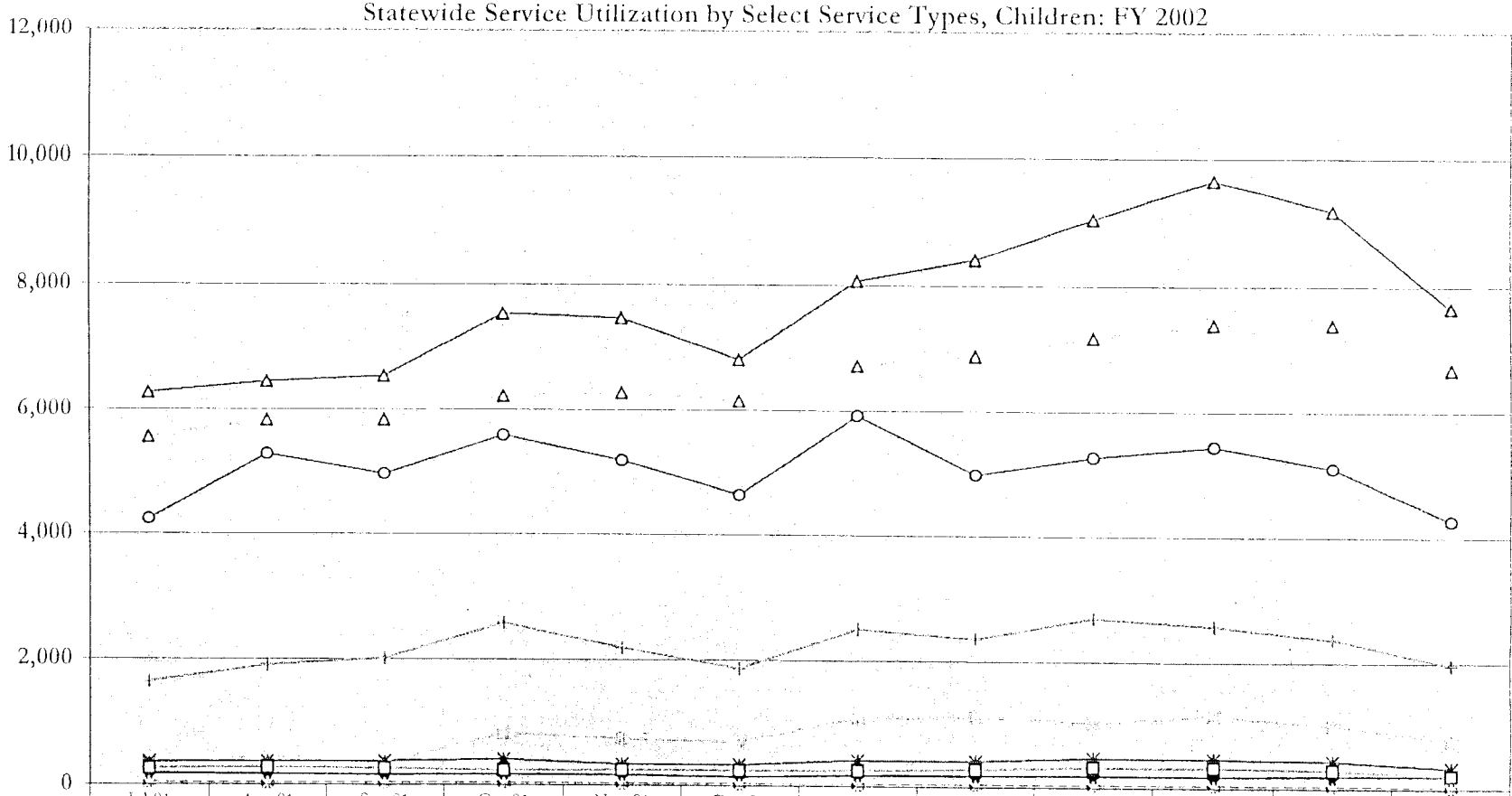
Total TennCare Eligibles include all individuals eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

* The sum of the eligibles in these charts do not include 209 eligibles of unknown race, 210 of unknown region, and 4 of unknown age that are included in the total (N).

Statewide Service Utilization by Select Service Types, Children: FY 2002

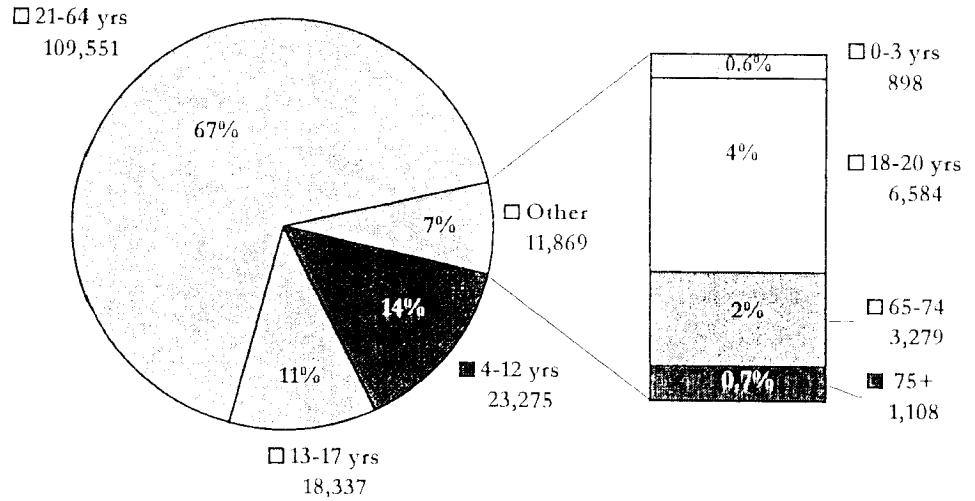
Children are defined as enrollees under age 18 as of the date of the service received.

Counts presented in the table reflect the number of unduplicated enrollees who received each service type for each month. A given enrollee is represented only once in each cell, but may be included in multiple months and service types.



	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02
24 Hr. Residential Treatment	189	179	166	180	173	149	182	189	197	192	204	211
Assessment	337	452	348	823	741	697	1,088	1,117	1,034	1,147	1,000	769
Case Management	5,559	5,839	5,843	6,219	6,275	6,152	6,721	6,881	7,177	7,391	7,388	6,681
Crisis Respite	10	8	2	2	6	1	2	1	-	2	1	3
Crisis Services	365	376	379	414	339	335	418	412	471	459	434	336
Day Treatment	33	28	31	34	21	20	18	39	36	38	36	15
EPSDT	1,647	1,911	2,019	2,592	2,195	1,870	2,514	2,372	2,700	2,578	2,383	1,971
Medication Management	4,238	5,288	4,968	5,593	5,195	4,639	5,923	4,986	5,273	5,444	5,108	4,263
Outpatient Therapy Services	6,273	6,449	6,536	7,539	7,469	6,806	8,071	8,409	9,052	9,659	9,184	7,659
Partial Hospitalization	35	43	43	44	33	32	50	50	51	48	38	24
Psychiatric Hospitalization	267	283	265	241	253	246	257	283	328	328	296	216
SA Inpatient	19	19	5	13	10	10	13	13	12	18	7	9
SA Outpatient	4	3	1	6	3	5	5	1		1	-	1
Transportation	552	599	580	653	623	584	709	718	782	789	693	623

Total Unduplicated Persons Served in FY 2002 by Age Group (N=163,110)*

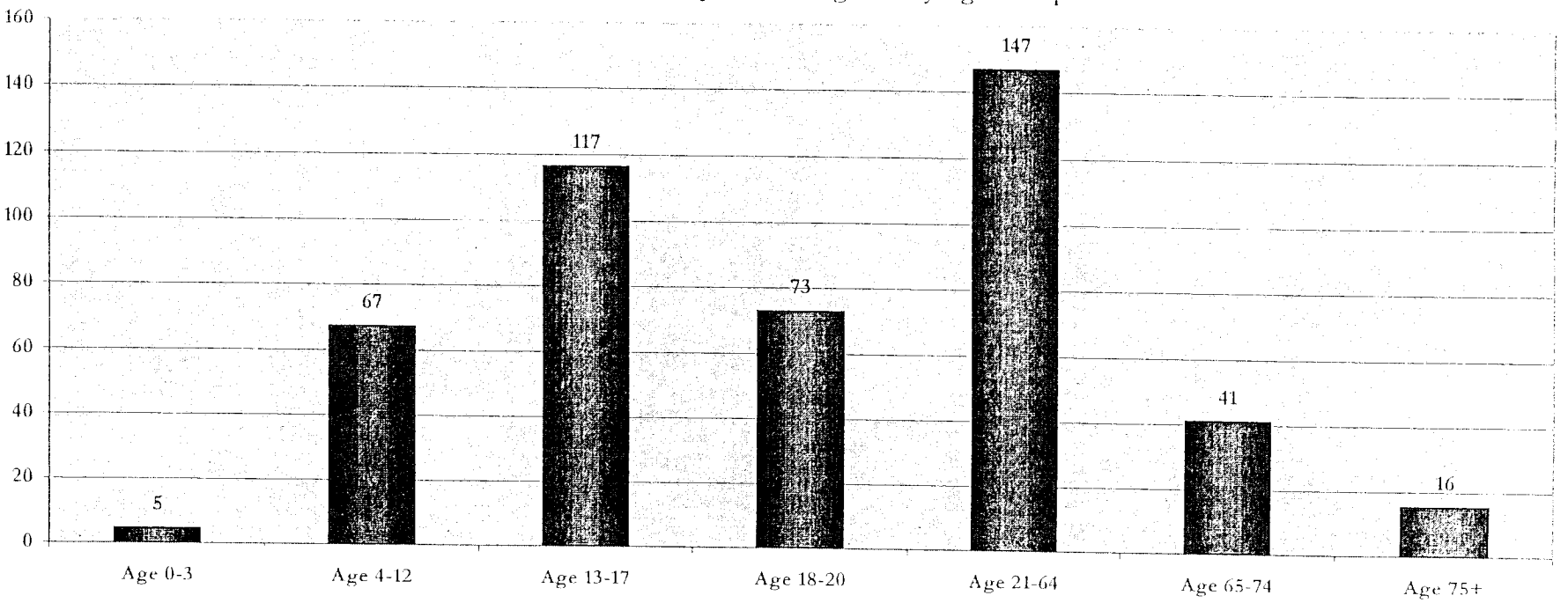


* The sum of the persons served in this chart does not include 78 consumers of unknown age that are included in the total (N).

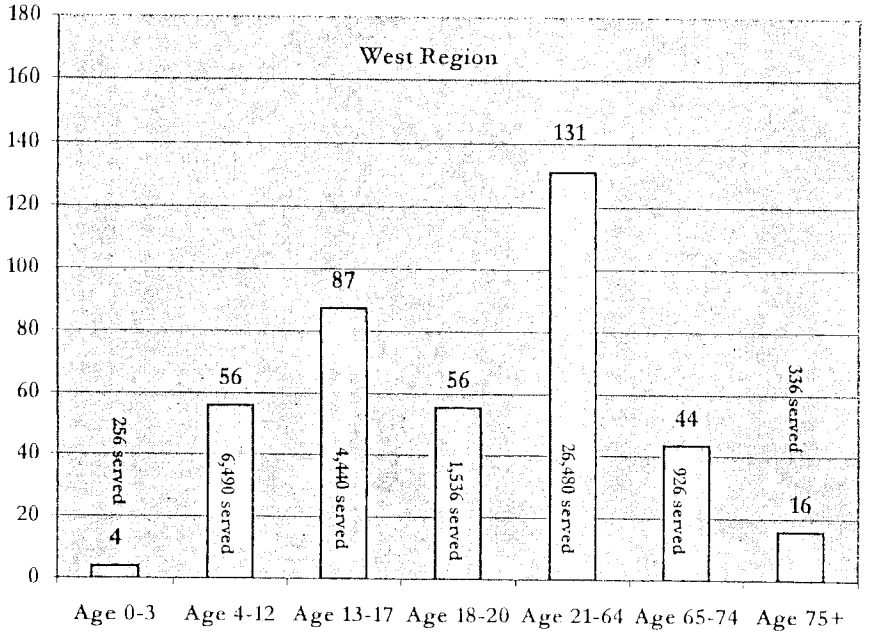
Unduplicated persons served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

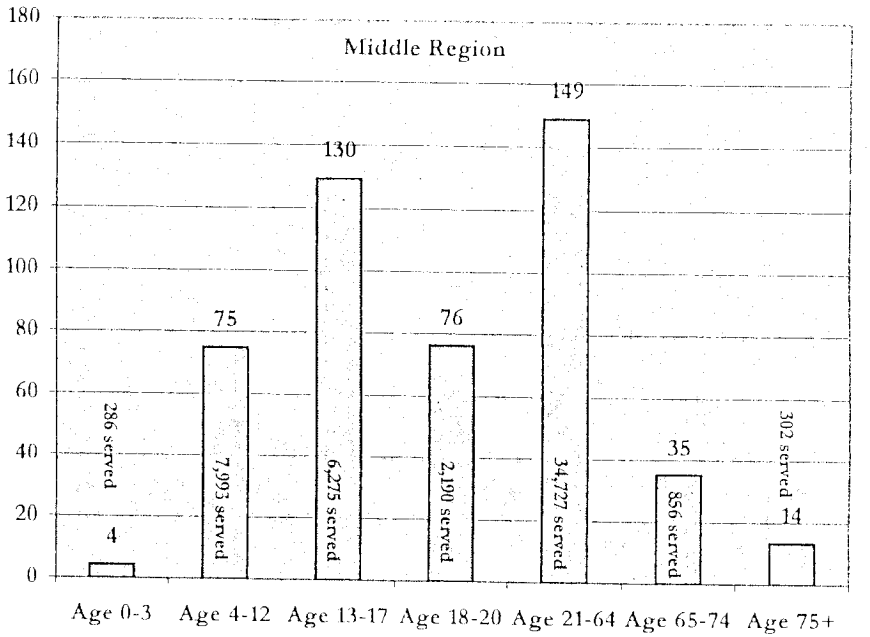
Rates are determined by dividing the number of persons served in each age group by the number of eligible enrollees in each group and multiplying by 1000.

Rate of Persons Served per 1000 Eligibles by Age Group



Rate of Total Persons Served per 1000 Eligibles and Number of Persons Served, TennCare Grand Regions by Age Group: FY 2002



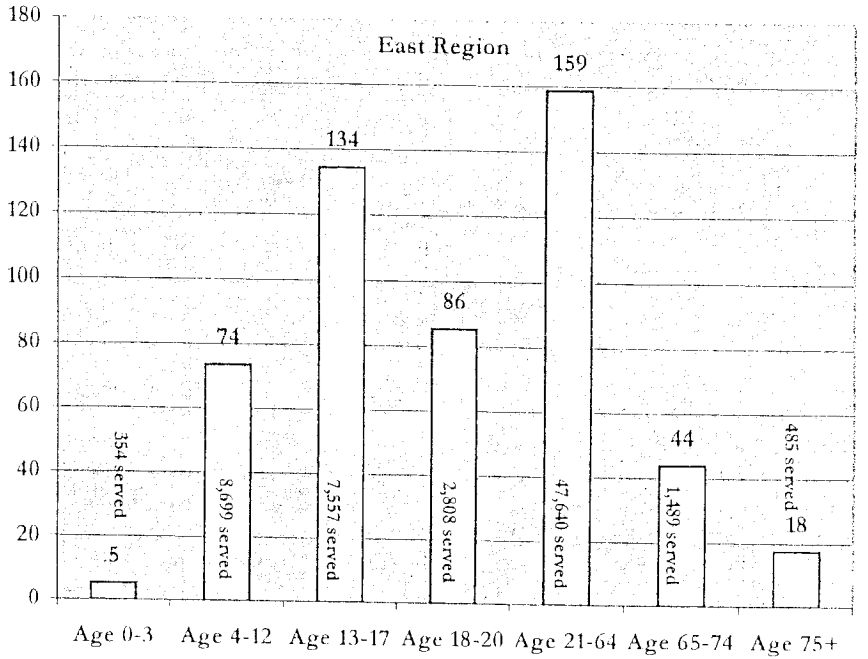


Rates are determined by dividing the number of persons served in each age group in each region by the number of TennCare eligible enrollees in each group and multiplying by 1000.

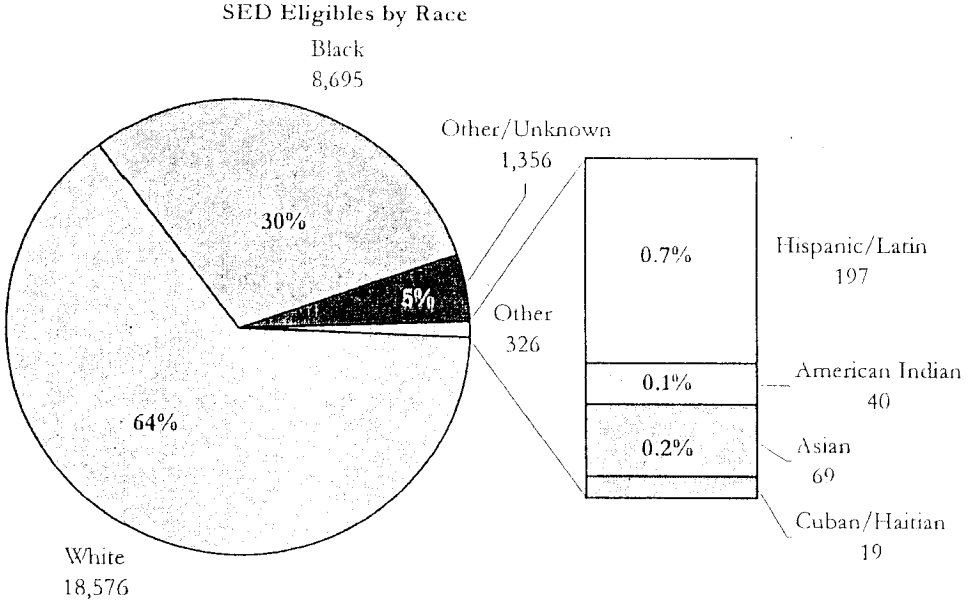
Persons served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is counted only once, regardless of the number of services received.

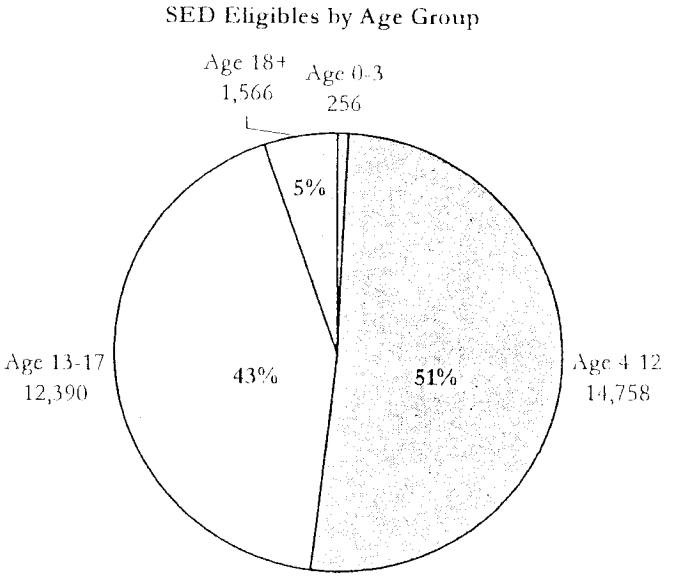
TennCare eligibles include all individuals eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

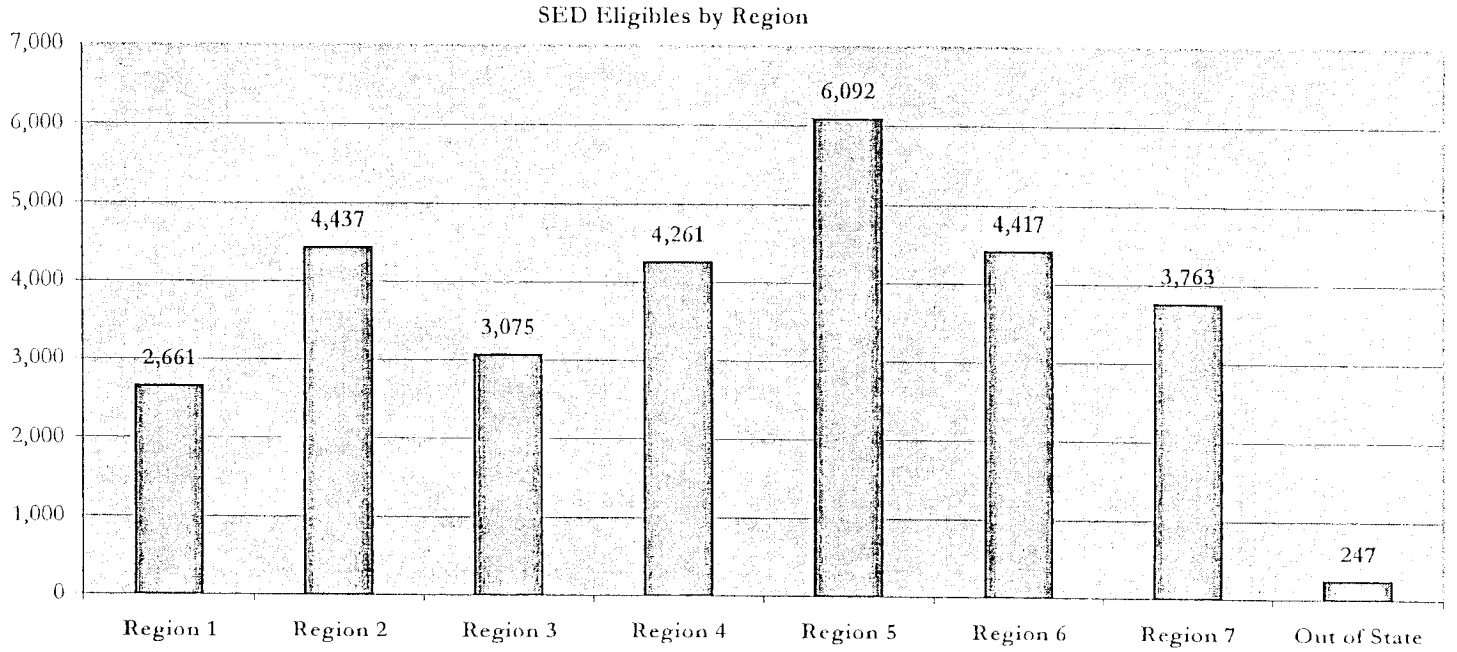
Tables reflect rates in the three TennCare Grand Regions. Not included are an additional 22,470 eligibles and 1,247 persons served outside of Tennessee.



Profile of SED TennCare Eligibles: FY 2002 (N=28,970)*



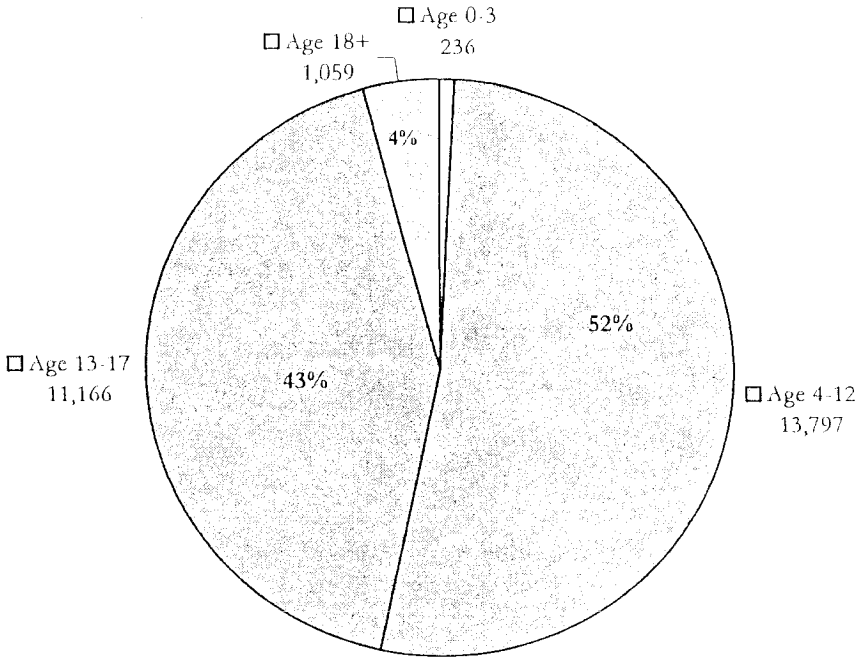




The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year. SED eligibles include all SED persons eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

The sum of the eligibles in these charts do not include 17 SED eligibles of unknown race and region that are included in the total (N).

Unduplicated SED Population Served in FY 2002 by Age (N=26,263)*



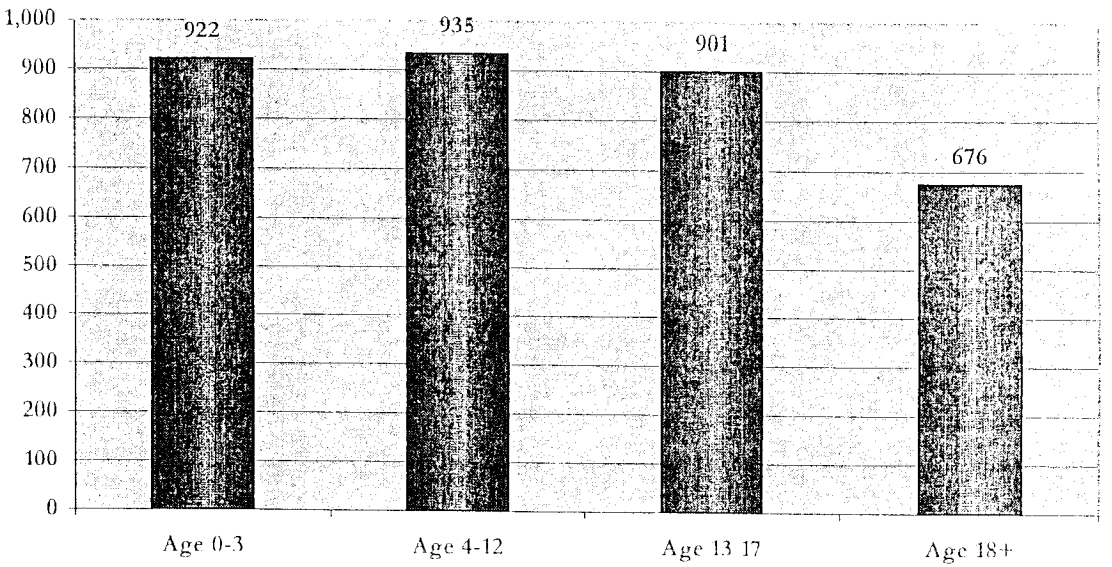
* The sum of the consumers served in this chart does not include 5 SED consumers of unknown age that are included in the total (N).

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

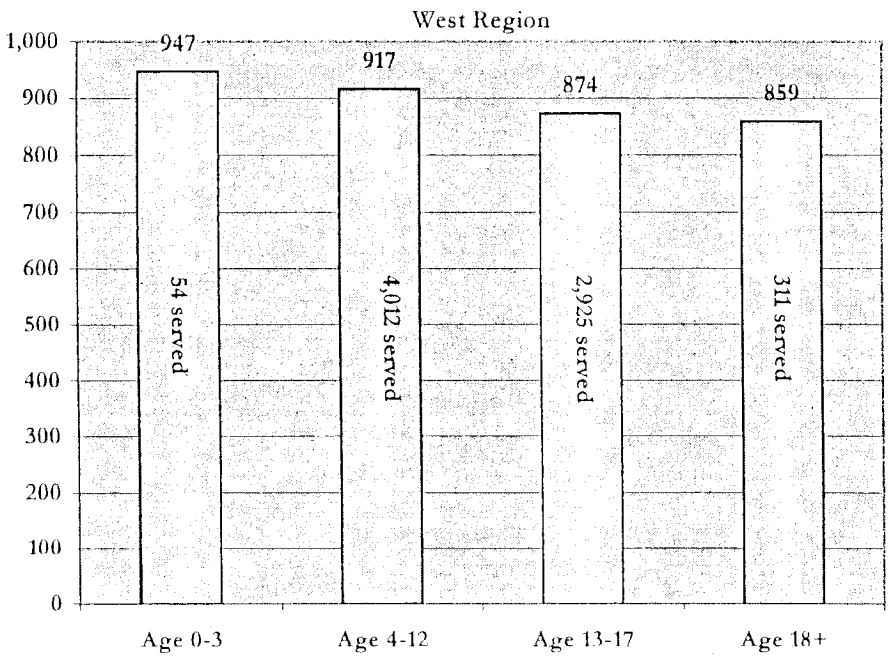
Unduplicated SED served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

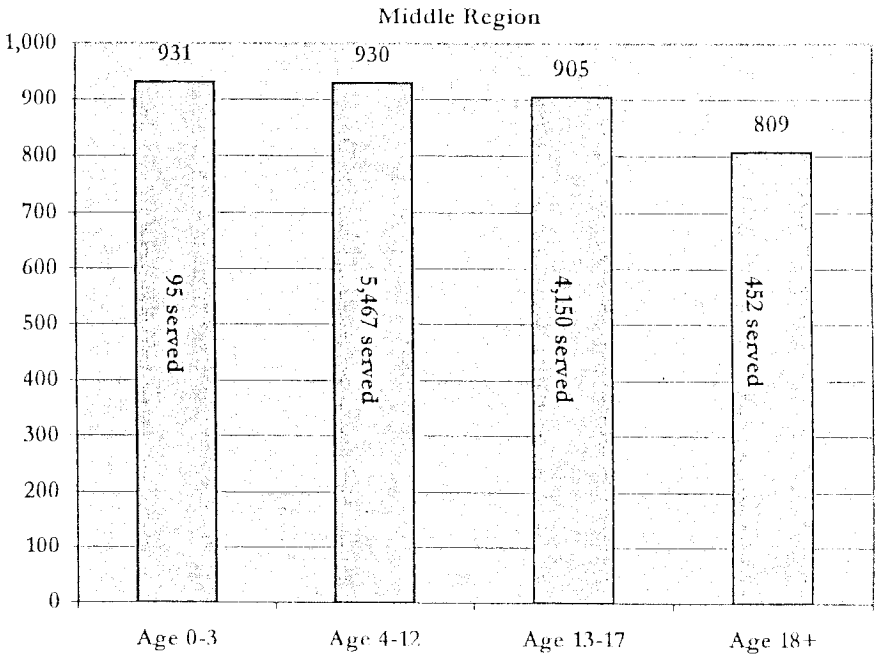
Rates are determined by dividing the number of SED persons served in each age group by the number of eligible SED enrollees in each group and multiplying by 1000.

Rate of SED Served per 1000 SED Eligibles



Rate of SED Served per 1000 SED Eligibles and Number of SED Served, TennCare Grand Regions by Age Group: FY 2002





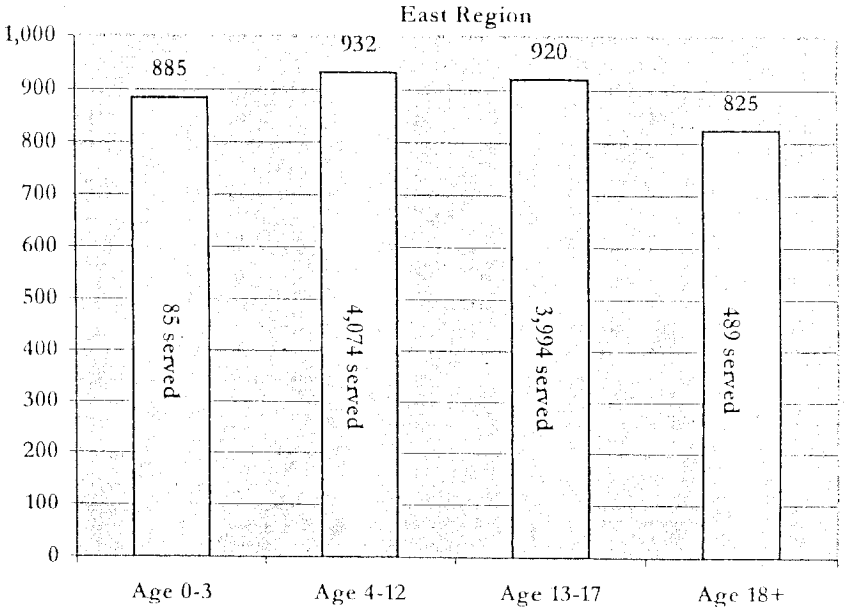
The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

Rates per 1000 are determined by dividing the number of SED persons served in each age group by the number of eligible SED enrollees in each group and multiplying by 1000.

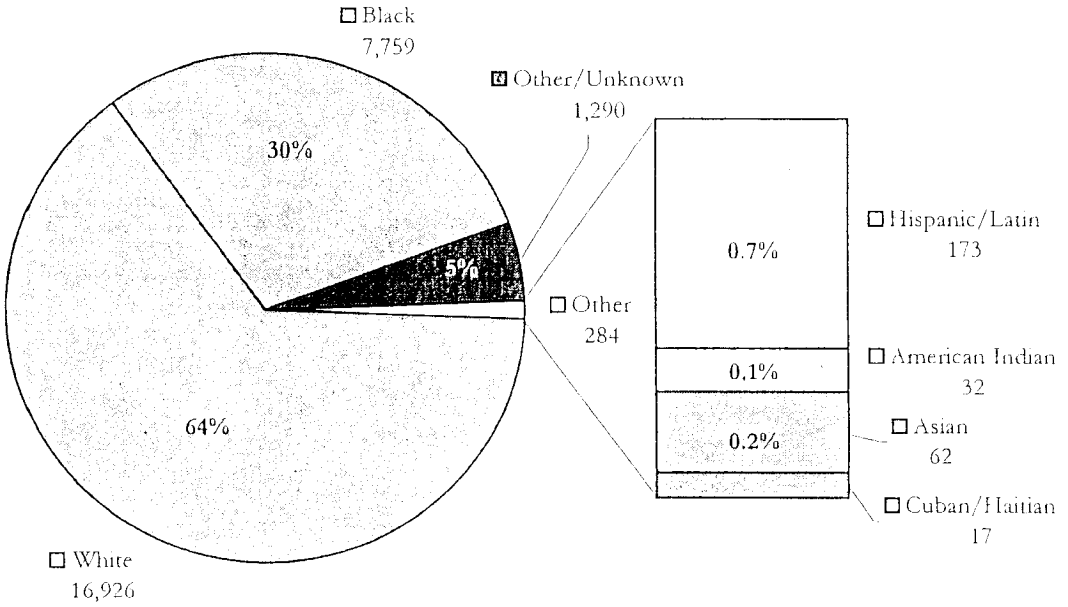
SED persons served refers to the number of unique SED enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is counted only once, regardless of the number of services received.

SED eligibles include all SED persons eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

Tables reflect rates in the three TennCare Grand Regions. Not included are an additional 247 SED eligibles and 155 SED served outside of Tennessee.



Unduplicated SED Population Served in FY 2002 by Race (N=26,263)*



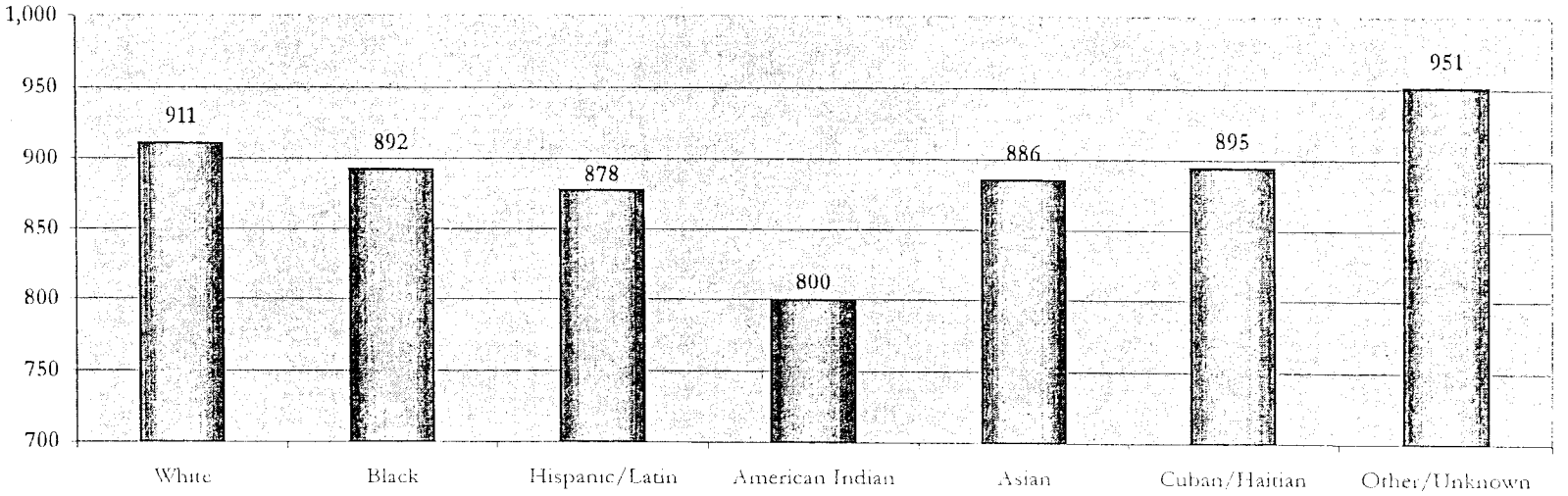
* The sum of the consumers served in this chart does not include 4 SED consumers of unknown race that are included in the total (N).

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service.

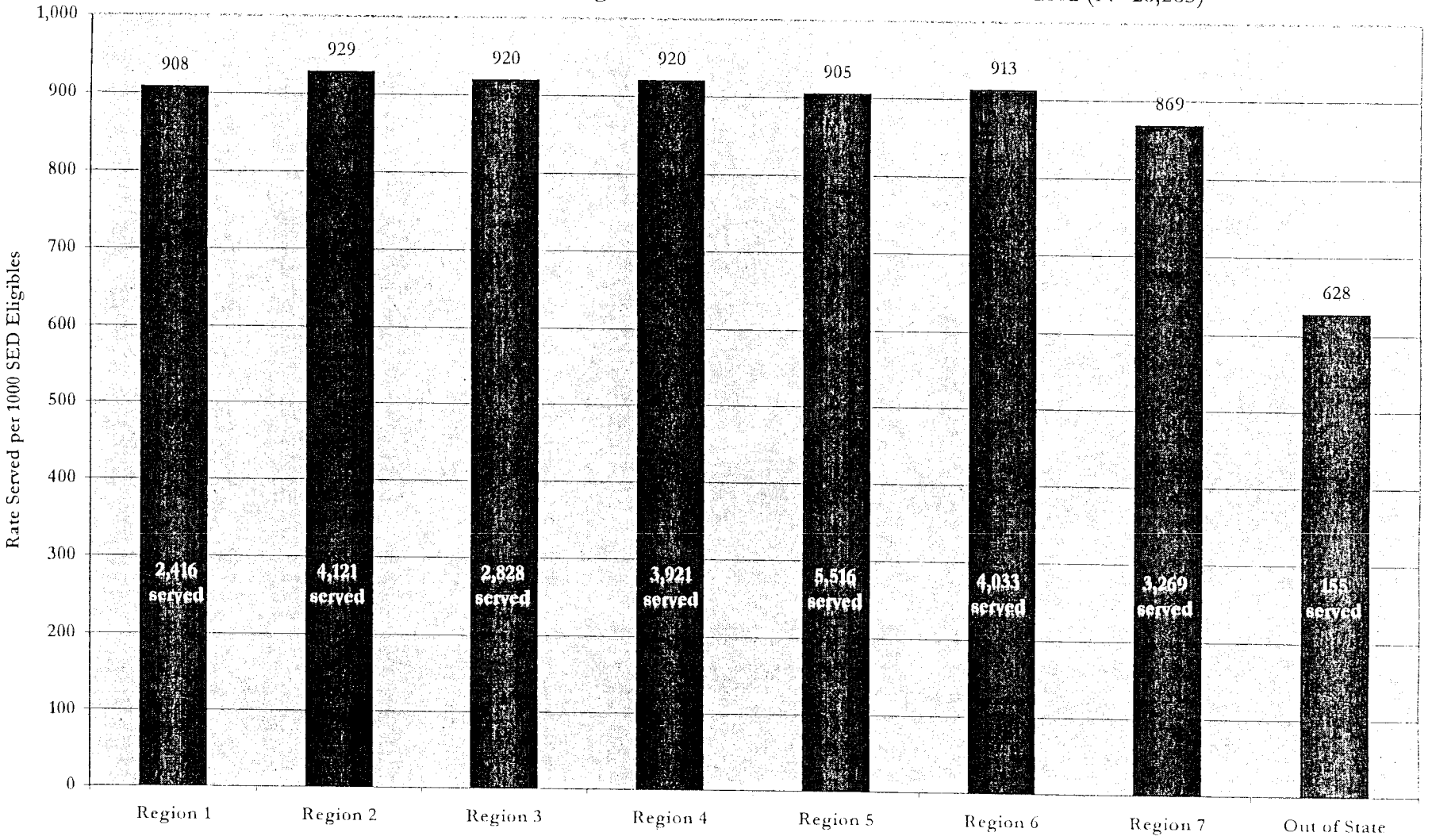
Unduplicated SED served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

Rates are determined by dividing the number of SED persons served in each racial group by the number of eligible SED enrollees in each group and multiplying by 1000.

Rate of SED Served per 1000 SED Eligibles



Rate of SED Served per 1000 SED Eligibles and Number of Persons Served: FY 2002 (N=26,263)



* The sum of the consumers served in this chart does not include 4 consumers of unknown region that are included in the total (N).

SED served refers to the number of unique SED enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received. The SED population is defined as all Severely Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

Rates are determined by dividing the number of persons served in each region by the number of eligible enrollees in each region and multiplying by 1000.

SED Served in FY 2002 by Select Types of Service, by Sex and Race

Service	Male (N=16,303)		Female (N=9,956)		White (N=16,926)		Black (N=7,759)		Other Races (N=1,578)		Total SED (N=26,263)	
	Unduplicated consumers	% of Males Served	Unduplicated consumers	% of Females Served	Unduplicated consumers	% of Whites Served	Unduplicated consumers	% of Blacks Served	Unduplicated consumers	% of Other Races Served	Unduplicated consumers	% of Total Served
24 Hr. Residential Treatment	337	2.1%	112	1.1%	332	2.0%	80	1.0%	37	2.3%	449	1.7%
Assessment	3,617	22.2%	2,190	22.0%	3,750	22.2%	1,711	22.1%	346	21.9%	5,807	22.1%
Case Management	8,511	52.2%	4,837	48.6%	7,591	44.8%	4,815	62.1%	942	59.7%	13,348	50.8%
Crisis Respite	19	0.1%	27	0.3%	35	0.2%	10	0.1%	1	0.1%	46	0.2%
Crisis Services	1,698	10.4%	1,355	13.6%	2,055	12.1%	835	10.8%	163	10.3%	3,053	11.6%
Day Treatment	108	0.7%	54	0.5%	142	0.8%	18	0.2%	2	0.1%	162	0.6%
EPSDT	8,513	52.2%	5,682	57.1%	9,605	56.7%	3,863	49.8%	727	46.1%	14,195	54.0%
Medication Management	9,419	57.8%	4,839	48.6%	8,848	52.3%	4,309	55.5%	1,101	69.8%	14,258	54.3%
Outpatient Therapy Services	10,487	64.3%	7,023	70.5%	11,588	68.5%	4,936	63.6%	986	62.5%	17,510	66.7%
Partial Hospitalization	171	1.0%	117	1.2%	196	1.2%	67	0.9%	25	1.6%	288	1.1%
Psychiatric Hospitalization	1,301	8.0%	991	10.0%	1,621	9.6%	533	6.9%	138	8.7%	2,292	8.7%
SA Inpatient	57	0.3%	28	0.3%	76	0.4%	5	0.1%	4	0.3%	85	0.3%
Transportation	1,539	9.4%	892	9.0%	1,159	6.8%	1,068	13.8%	204	12.9%	2,431	9.3%

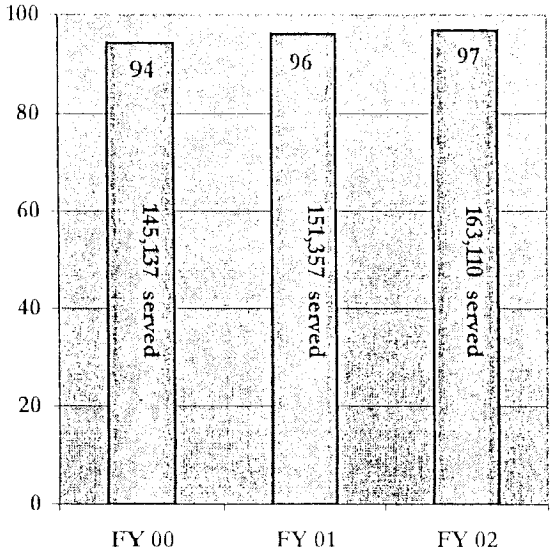
SED served refers to the number of unique enrollees who received each selected service type 7/1/01 to 6/30/02. The table presents both the number of unduplicated SED consumers who received each type of service and the percentage of total SED persons served (N) for each category. For example, of the total SED males served (16,303), 3,617 (or 22.2% of the total SED males served) received assessment services. Of the SED females served, 2,190 received this service, or 22.0% of the 9,956 SED females served.

The sum of the consumers of each service type does not equal the total number of persons served (N) and the sum of percentages does not equal 100%, because a given enrollee may be represented in multiple service types.

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

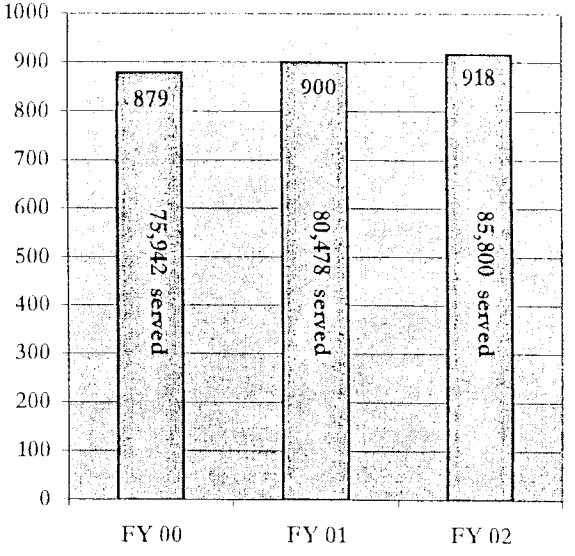
Rate of Persons Served per 1000 Eligibles: FY 2000, FY 2001, FY 2002

Total Population



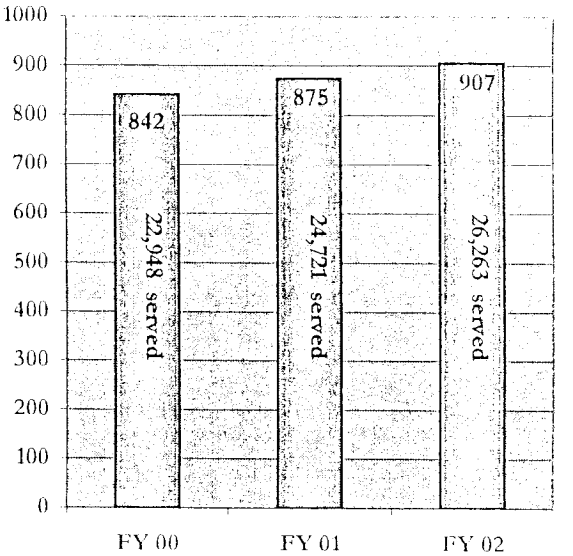
Rates for total population, SPMI, and SED are determined by dividing the number of persons served in each group by the number of eligible enrollees in each group and multiplying by 1000.

SPMI Population



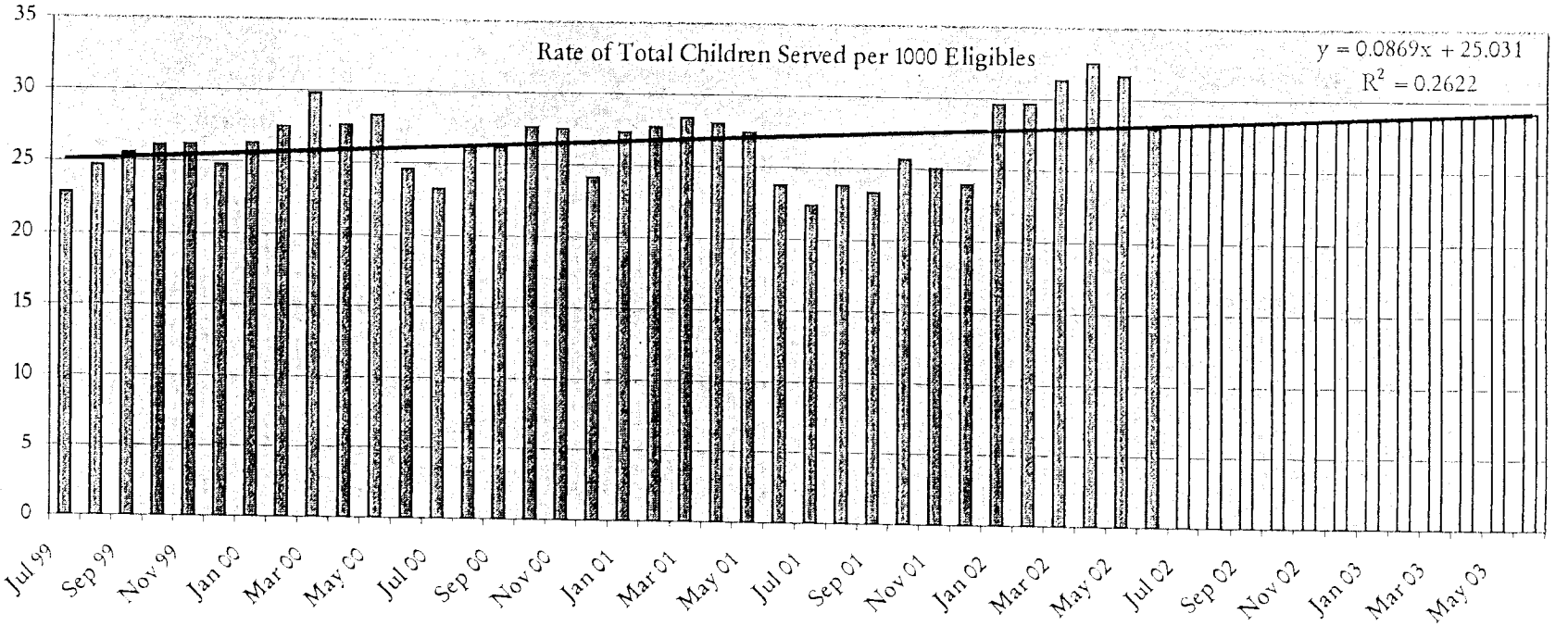
The SPMI population is defined as all Severely or Persistently Mentally Ill adults (a current CRG 1, CRG 2, or CRG 3 assessment). A current assessment is defined as within one year of the date of service.

SED Population

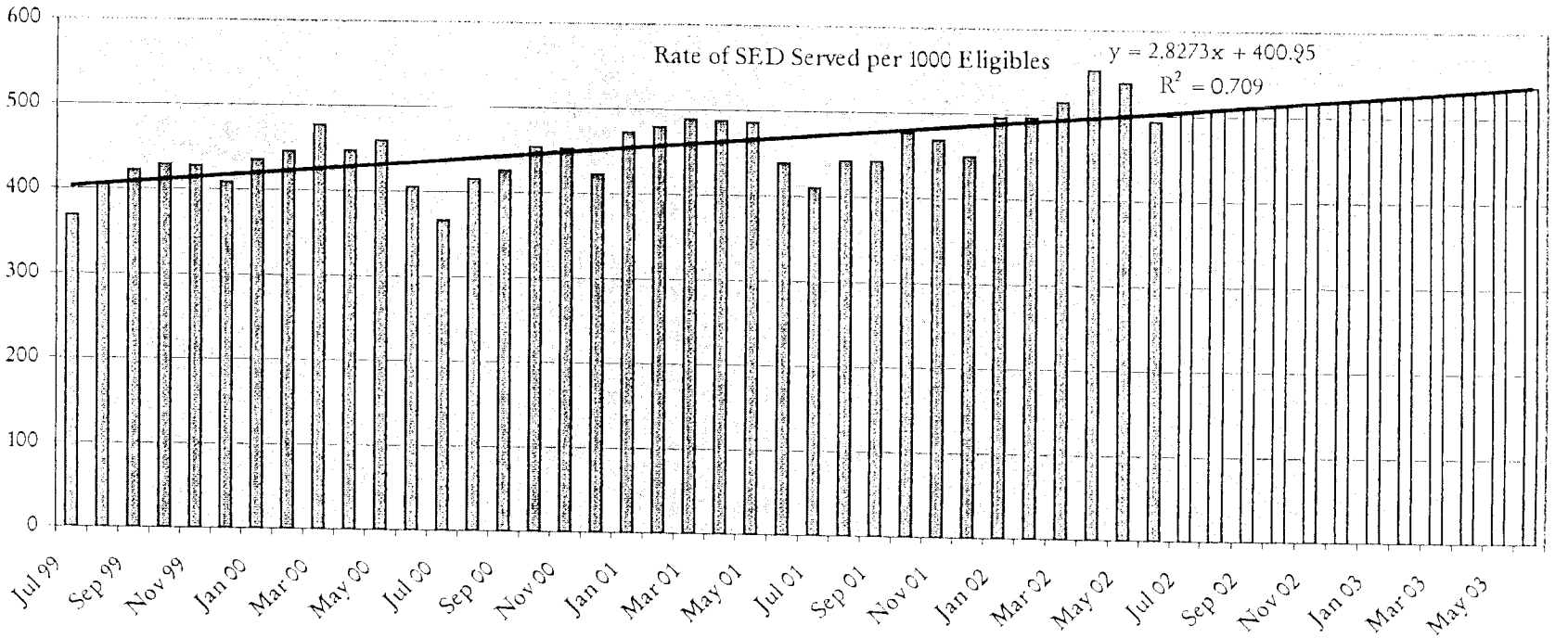


The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

Children are defined as all persons under the age of 18. The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service.



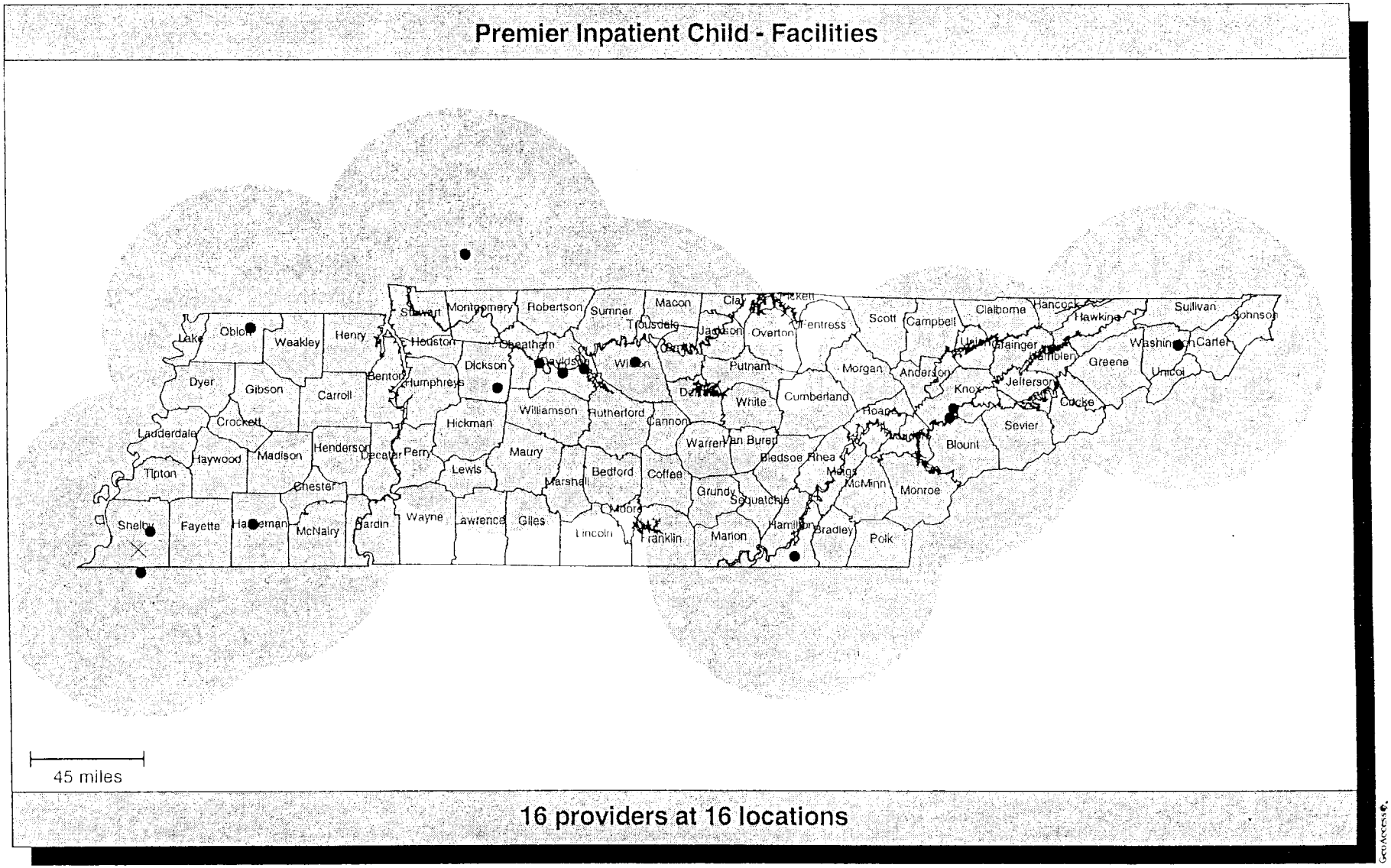
Rates per 1000 are determined by dividing the number of children or SED persons served in each month by the number of eligible children or SED enrollees in each month and multiplying by 1000.



CHILDREN & YOUTH PROVIDER NETWORK
OCTOBER - DECEMBER 2002

State of Tennessee
Bureau of TennCare and
Department of Mental Health and Developmental Disabilities
Office of Managed Care
Cordell Hull Building - 5th Floor
Nashville, TN 37243

Provider locations



- Single provider locations (14)
- × Multiple provider locations (2)
- ☐ 60 mile radius

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PRENTISS - MS			
MARIETTA	38856	2	73.1
PENDER - NC			
BURGAW	28425	1	76.6
CARROLL - TN			
YUMA	38390	13	64.2
CUMBERLAND - TN			
CROSSVILLE	38571	1,123	64.6
PLEASANT HILL	38578	95	65.2
FENTRESS - TN			
CLARKRANGE	38553	322	66.4
GRIMSLEY	38565	195	68.9
JAMESTOWN	38556	1,743	71.2
WILDER	38589	29	65.4
FRANKLIN - TN			
HUNTLAND	37345	218	64.4
GILES - TN			
ARDMORE	38449	195	78.0
ELKTON	38455	60	76.7
GOODSPRING	38460	162	68.1
MINOR HILL	38473	90	72.0
PROSPECT	38477	211	74.8
PULASKI	38478	1,671	64.6
LAWRENCE - TN			
FIVE POINTS	38457	77	70.7
LORETTO	38469	315	70.3
SAINT JOSEPH	38481	92	75.8
WESTPOINT	38486	97	67.2
LINCOLN - TN			
DELLROSE	38453	34	71.1
ELORA	37328	129	69.5
FAYETTEVILLE	37334	1,795	73.0
FLINTVILLE	37335	270	73.2
FRANKEWING	38459	32	65.9
KELSO	37348	132	75.0
MULBERRY	37359	40	71.6
TAFT	38488	193	77.9
MOORE - TN			
LYNCHBURG	37352	201	65.4

Provider group: Premier Inpatient Child - Facilities

ZIP Code detail information

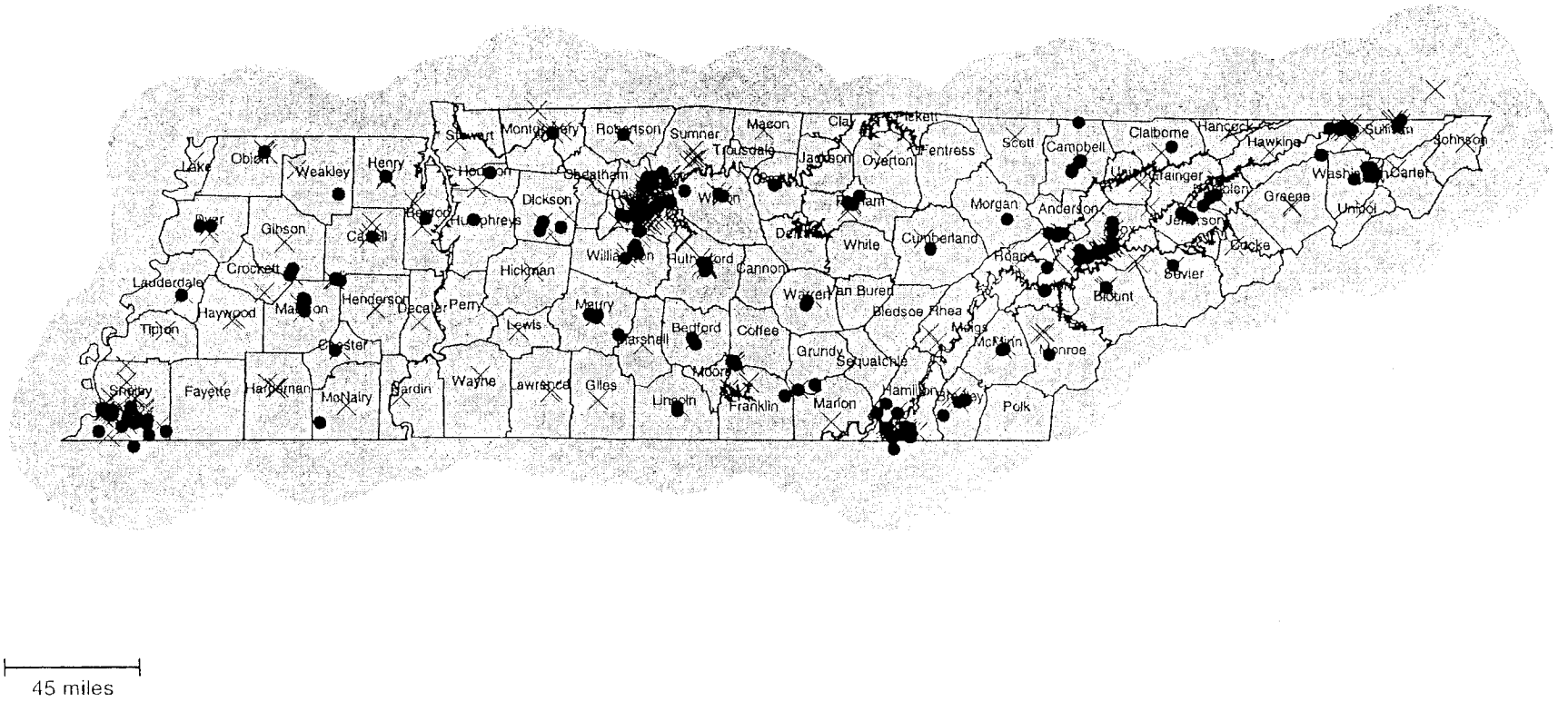
Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
OVERTON - TN			
ALLONS	38541	163	64.7
ALPINE	38543	53	68.3
CRAWFORD	38554	112	64.3
MONROE	38573	221	68.6
PICKETT - TN			
BYRDSTOWN	38549	451	75.5
PALL MALL	38577	154	80.3
WAYNE - TN			
COLLINWOOD	38450	342	72.7
CYPRESS INN	38452	102	75.9
IRON CITY	38463	316	76.7
LUTTS	38471	70	68.7
WAYNESBORO	38485	805	64.0
TOTALS		**12,326**	**69.6**

Provider group: Premier Inpatient Child - Facilities

Provider locations

Premier Outpatient Child - Facilities



922 providers at 559 locations

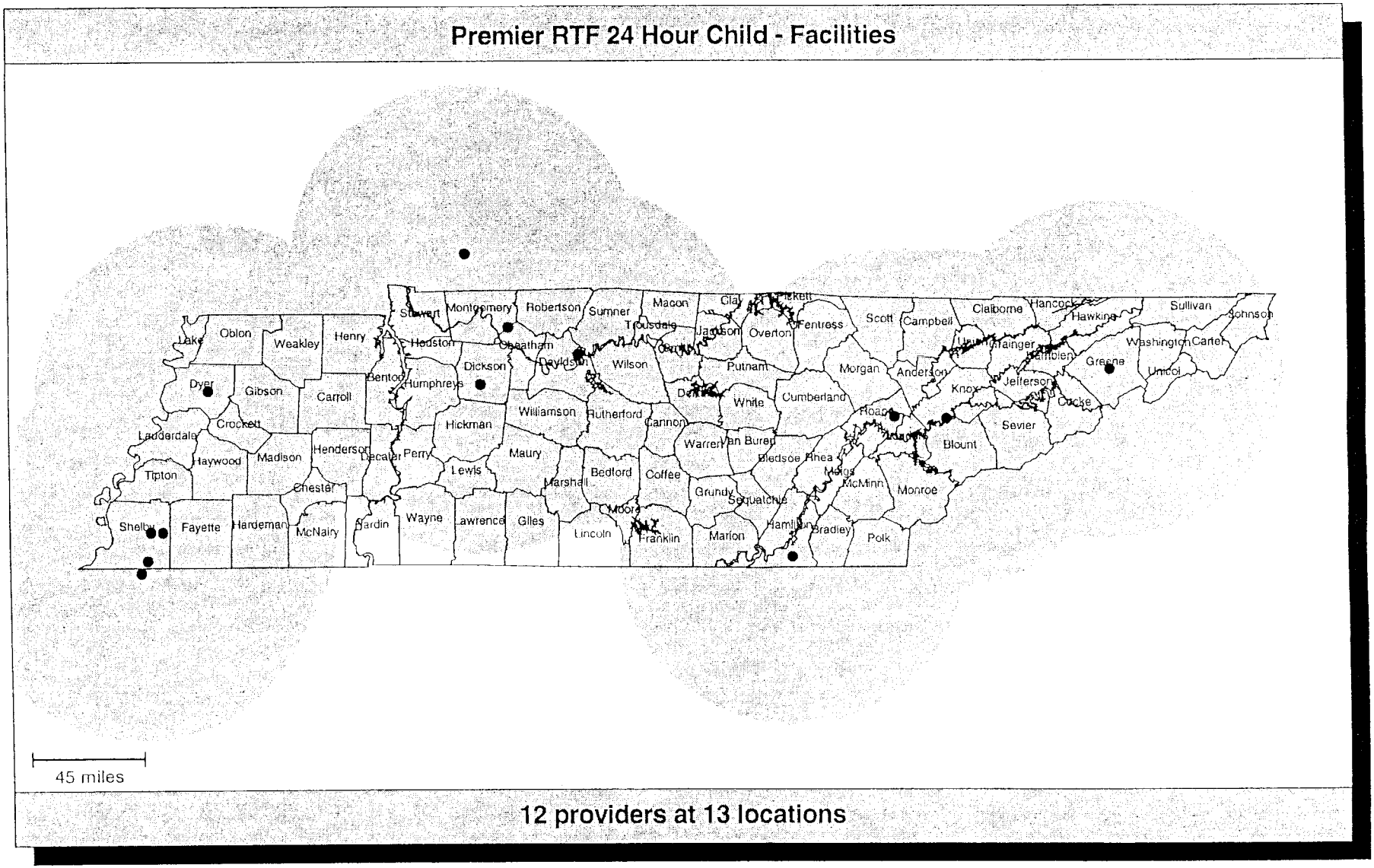
- ● Single provider locations (223)
- × Multiple provider locations (336)
- ▨ 30 mile radius

ZIP Code detail information

Premier Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
NO MEMBERS MEET THE SPECIFICATIONS			

Provider group: Premier Outpatient Child - Facilities

Provider locations



ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PENDER - NC			
BURGAW	28425	1	76.9
CHESTER - TN			
ENVILLE	38332	39	75.1
CLAY - TN			
CELINA	38551	559	75.9
GILES - TN			
ARDMORE	38449	195	87.2
ELKTON	38455	60	83.9
MINOR HILL	38473	90	76.7
PROSPECT	38477	211	80.0
HARDIN - TN			
COUNCE	38326	71	83.0
CRUMP	38327	37	79.2
MORRIS CHAPEL	38361	43	79.1
OLIVEHILL	38475	26	76.7
SALTILLO	38370	17	77.9
SAVANNAH	38372	797	83.3
SHILOH	38376	19	77.8
HENDERSON - TN			
REAGAN	38368	86	75.1
SARDIS	38371	26	76.4
JOHNSON - TN			
LAUREL BLOOMERY	37680	79	75.9
LAWRENCE - TN			
SAINT JOSEPH	38481	92	74.5
LINCOLN - TN			
DELLROSE	38453	34	81.0
FAYETTEVILLE	37334	1,795	78.7
FRANKEWING	38459	32	75.5
KELSO	37348	132	75.1
MULBERRY	37359	40	75.3
TAFT	38488	193	84.6
MCNAIRY - TN			
ADAMSVILLE	38310	309	75.0
MICHIE	38357	187	77.1
MILLEDGEVILLE	38359	7	79.6
OVERTON - TN			
ALLONS	38541	163	78.1

Provider group: Premier RTF 24 Hour Child - Facilities

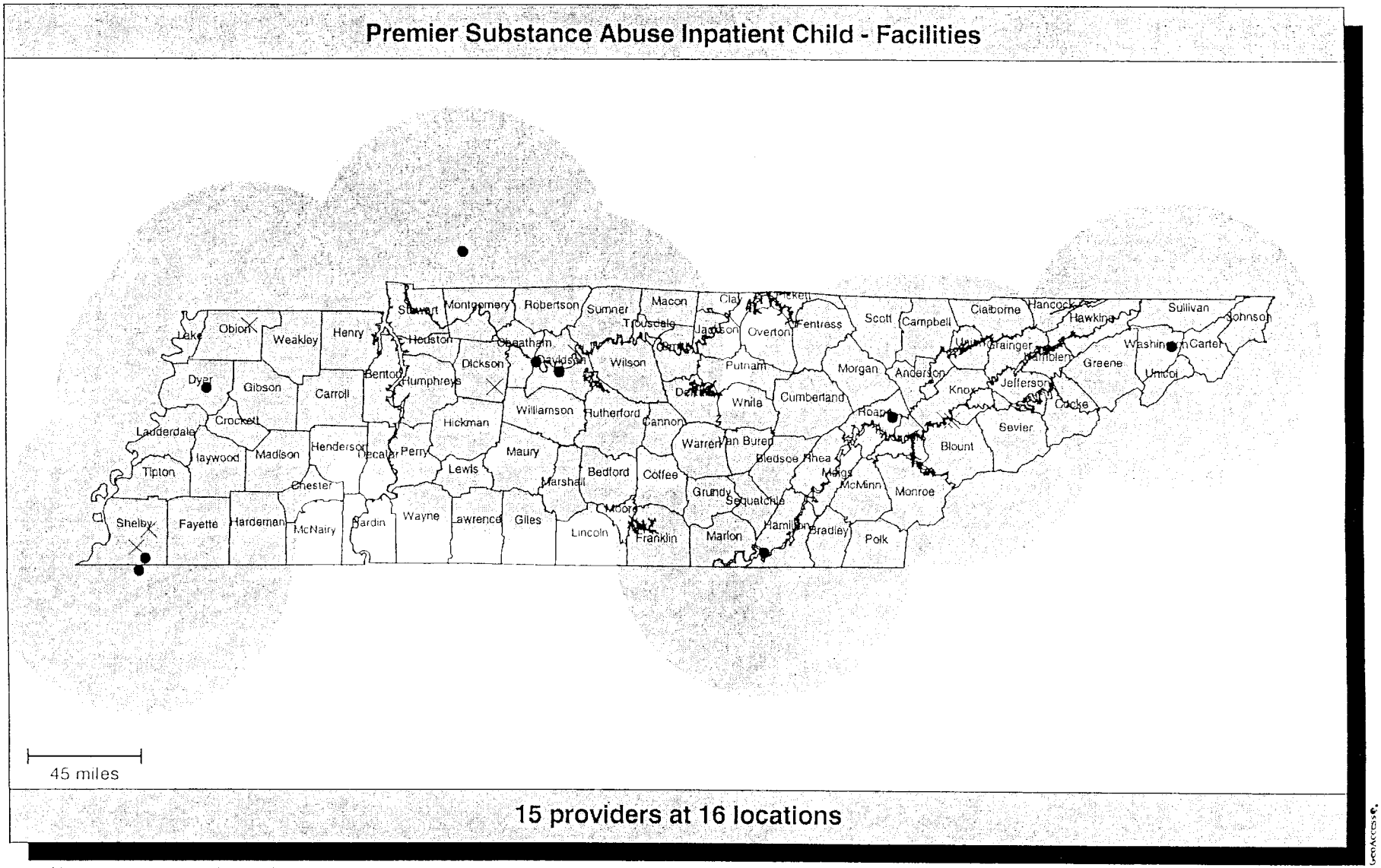
ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
WAYNE - TN			
CYPRESS INN	38452	102	80.0
IRON CITY	38463	316	75.5
LUTTS	38471	70	82.8
TOTALS		**5,828**	**79.0**

Provider group: Premier RTF 24 Hour Child - Facilities

Provider locations



- ● Single provider locations (9)
- × Multiple provider locations (7)
- ☐ 60 mile radius

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
MADISON - AL			
HUNTSVILLE	35806	1	67.0
PENDER - NC			
BURGAW	28425	1	79.0
BEDFORD - TN			
NORMANDY	37360	137	64.4
CHESTER - TN			
ENVILLE	38332	39	78.0
HENDERSON	38340	364	67.2
JACKS CREEK	38347	25	72.3
LURAY	38352	12	67.5
CLAY - TN			
CELINA	38551	559	75.9
MOSS	38575	154	69.2
DECATUR - TN			
BATH SPRINGS	38311	17	74.1
DECATURVILLE	38329	113	69.2
GILES - TN			
ARDMORE	38449	195	78.0
ELKTON	38455	60	76.7
GOODSPRING	38460	162	68.1
MINOR HILL	38473	90	72.0
PROSPECT	38477	211	74.8
PULASKI	38478	1,671	64.6
HARDIN - TN			
COUNCE	38326	71	85.8
CRUMP	38327	37	84.1
MORRIS CHAPEL	38361	43	83.7
OLIVEHILL	38475	26	79.9
SALTILLO	38370	17	81.8
SAVANNAH	38372	797	87.8
SHILOH	38376	19	82.6
HENDERSON - TN			
DARDEN	38328	38	67.8
HURON	38345	70	65.2
LEXINGTON	38351	846	65.7
REAGAN	38368	86	75.5
SARDIS	38371	26	80.4
SCOTTS HILL	38374	66	76.1

Provider group: Premier Substance Abuse Inpatient Child - Facilities

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
HENDERSON - TN			
WILDERSVILLE	38388	59	64.0
LAWRENCE - TN			
FIVE POINTS	38457	77	70.7
LORETTO	38469	315	70.3
SAINT JOSEPH	38481	92	75.8
WESTPOINT	38486	97	67.2
LINCOLN - TN			
DELLROSE	38453	34	71.1
FAYETTEVILLE	37334	1,795	71.2
FRANKEWING	38459	32	65.9
KELSO	37348	132	64.2
MULBERRY	37359	40	64.8
TAFT	38488	193	76.8
MCNAIRY - TN			
ADAMSVILLE	38310	309	79.9
BETHEL SPRINGS	38315	201	65.7
CHEWALLA	38393	4	65.9
FINGER	38334	59	70.1
GUYS	38339	45	73.3
MICHIE	38357	187	79.7
MILLEDGEVILLE	38359	7	83.1
RAMER	38367	155	70.3
SELMER	38375	614	68.2
STANTONVILLE	38379	55	77.6
OVERTON - TN			
ALLONS	38541	163	78.1
ALLRED	38542	3	64.0
ALPINE	38543	53	66.0
HILHAM	38568	228	72.0
LIVINGSTON	38570	852	71.7
MONROE	38573	221	72.3
RICKMAN	38580	158	67.6
PICKETT - TN			
BYRDSTOWN	38549	451	73.5
PALL MALL	38577	154	68.3
PUTNAM - TN			
COOKEVILLE	38501	2,854	66.9
	38502	105	67.9

Provider group: Premier Substance Abuse Inpatient Child - Facilities

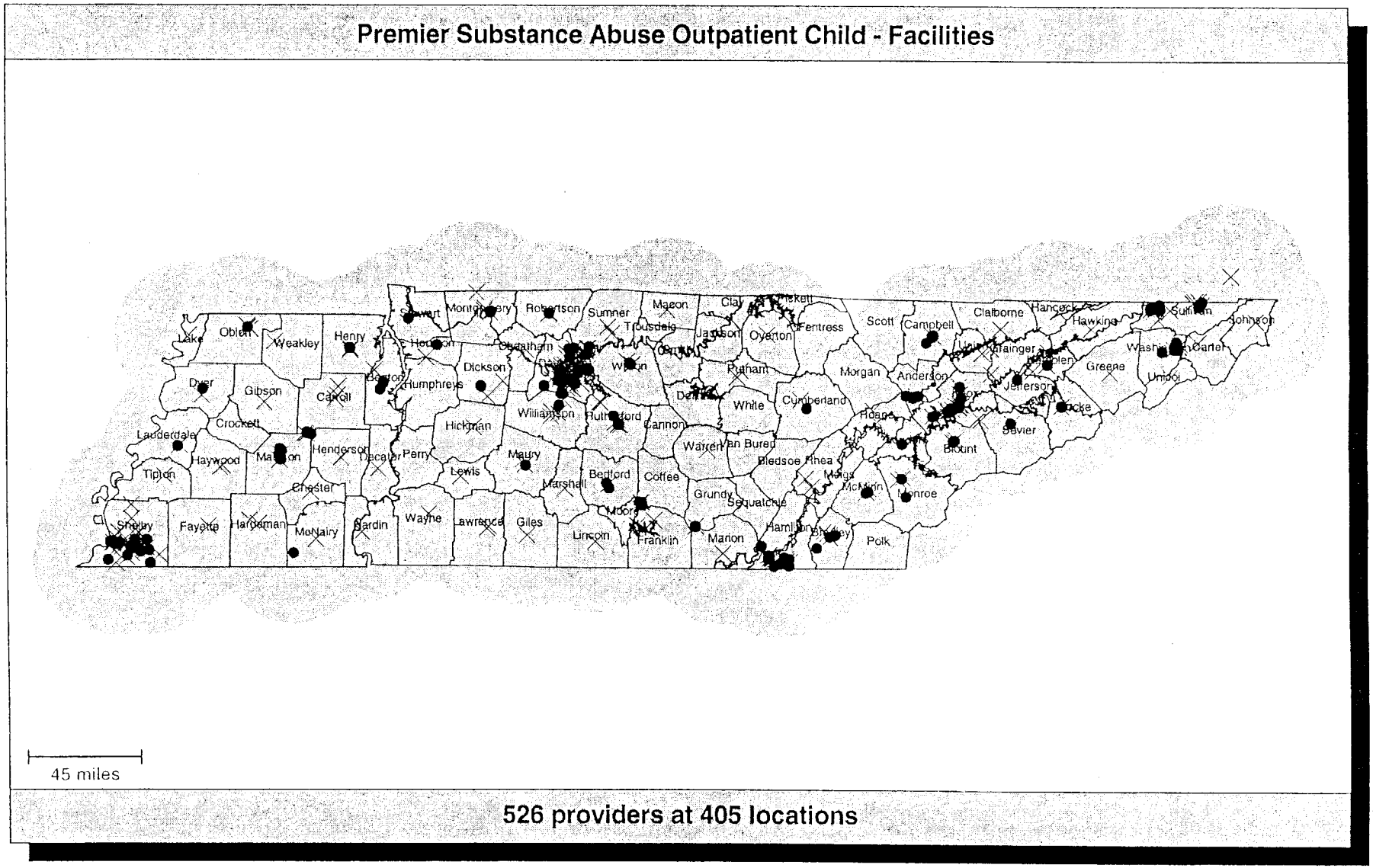
ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PUTNAM - TN			
COOKEVILLE	38503	52	68.4
	38505	4	65.8
	38506	1,829	68.5
WAYNE - TN			
CLIFTON	38425	182	71.0
COLLINWOOD	38450	342	74.2
CYPRESS INN	38452	102	82.2
IRON CITY	38463	316	77.2
LUTTS	38471	70	85.0
WAYNESBORO	38485	805	64.5
TOTALS		**19,399**	**70.5**

Provider group: Premier Substance Abuse Inpatient Child - Facilities

Provider locations



- Single provider locations (152)
- × Multiple provider locations (253)

30 mile radius

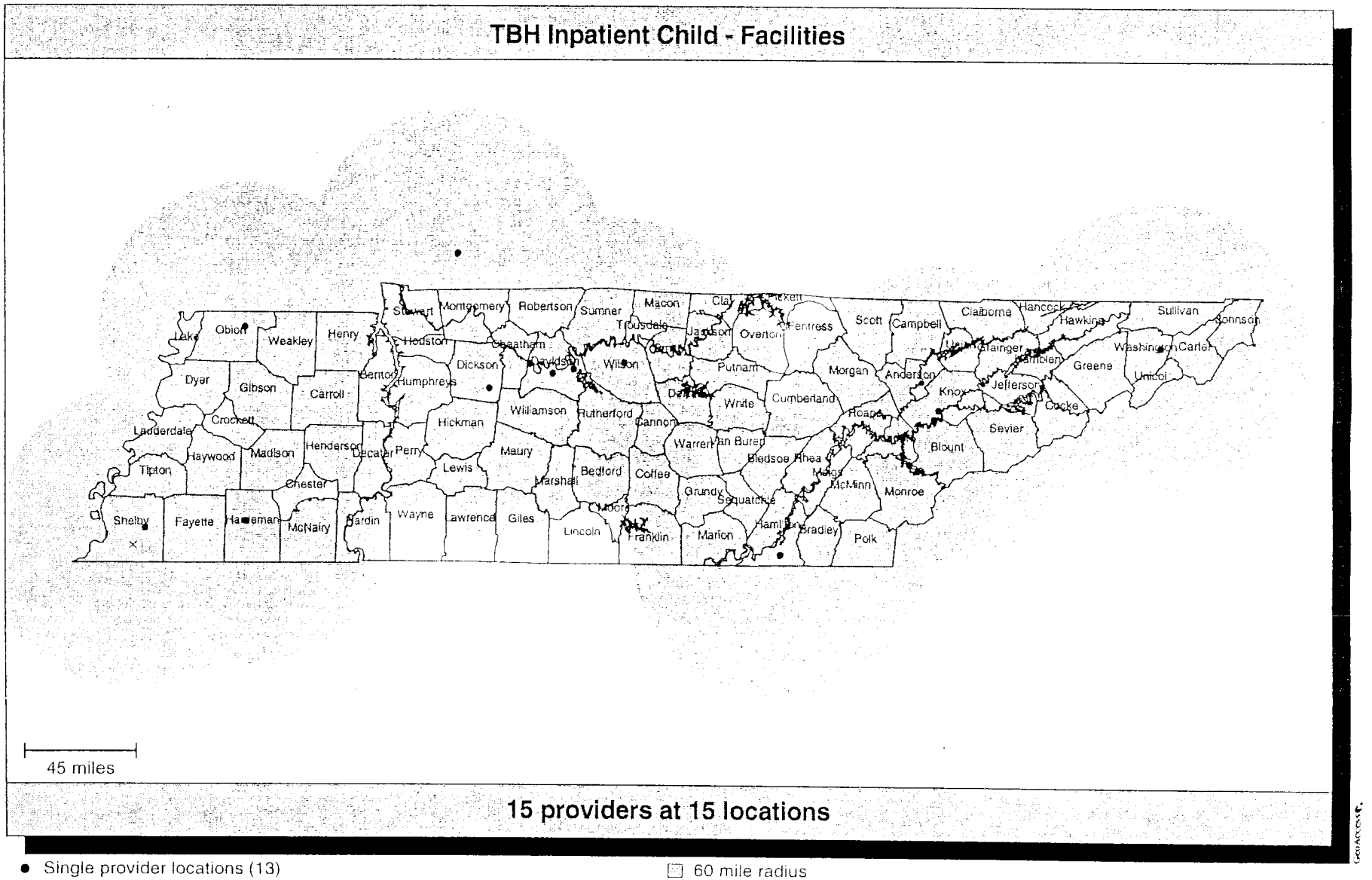
ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
NO MEMBERS MEET THE SPECIFICATIONS			

Provider group: Premier Substance Abuse Outpatient Child - Facilities

Provider locations



- Single provider locations (13)
- × Multiple provider locations (2)
- ☐ 60 mile radius

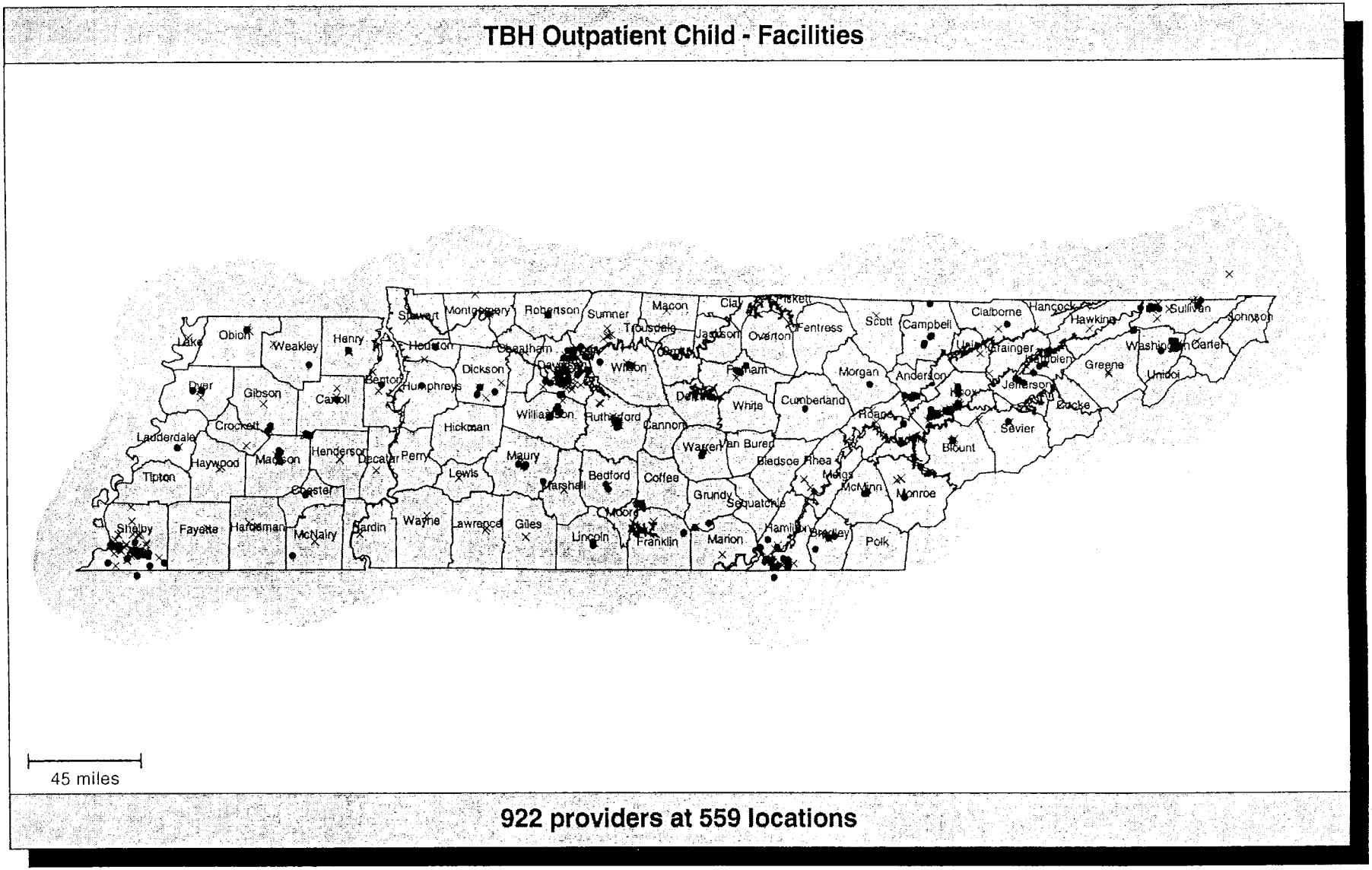
ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
FENTRESS - TN			
JAMESTOWN	38556	4	71.3
FRANKLIN - TN			
HUNTLAND	37345	3	65.0
GILES - TN			
GOODSPRING	38460	1	66.6
HENDERSON - TN			
DARDEN	38328	51	64.1
LINCOLN - TN			
FAYETTEVILLE	37334	2	70.9
FLINTVILLE	37335	2	68.1
TOTALS		63	65.0

Provider group: TBH Inpatient Child - Facilities

Provider locations



ZIP Code detail information

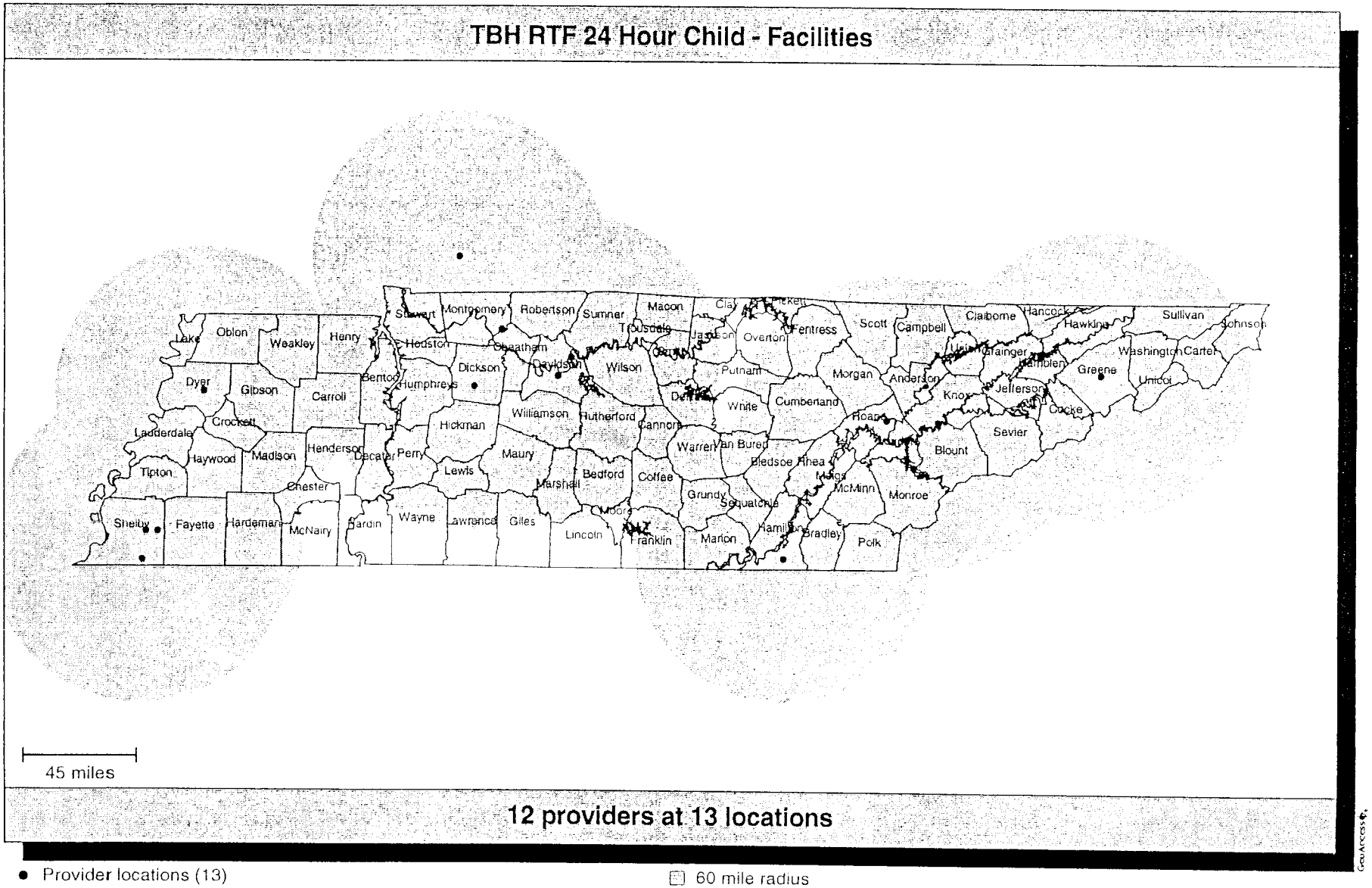
TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider

NO MEMBERS MEET THE SPECIFICATIONS

Provider group: TBH Outpatient Child - Facilities

Provider locations



● Provider locations (13)

▭ 60 mile radius

ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
CHESTER - TN			
ENVILLE	38332	83	76.1
HENDERSON	38340	743	65.5
JACKS CREEK	38347	59	72.3
LURAY	38352	42	66.2
COFFEE - TN			
MANCHESTER	37355	2	65.4
TULLAHOMA	37388	21	69.1
DECATUR - TN			
BATH SPRINGS	38311	41	69.8
DECATURVILLE	38329	213	65.6
FRANKLIN - TN			
HUNTLAND	37345	3	65.0
GILES - TN			
GOODSPRING	38460	1	71.6
PULASKI	38478	1	67.0
HARDIN - TN			
COUNCE	38326	104	84.4
CRUMP	38327	44	78.0
MORRIS CHAPEL	38361	85	79.8
OLIVEHILL	38475	84	76.7
PICKWICK DAM	38365	13	85.8
SALTILLO	38370	57	78.1
SAVANNAH	38372	1,679	83.3
SHILOH	38376	49	78.0
HENDERSON - TN			
LEXINGTON	38351	785	65.9
REAGAN	38368	140	74.7
SARDIS	38371	79	77.8
SCOTTS HILL	38374	137	71.6
JOHNSON - TN			
LAUREL BLOOMERY	37680	11	73.2
MOUNTAIN CITY	37683	76	68.6
SHADY VALLEY	37688	1	67.7
TRADE	37691	7	66.9
LINCOLN - TN			
FAYETTEVILLE	37334	2	71.3
FLINTVILLE	37335	2	68.1

Provider group: TBH RTF 24 Hour Child - Facilities

ZIP Code detail information

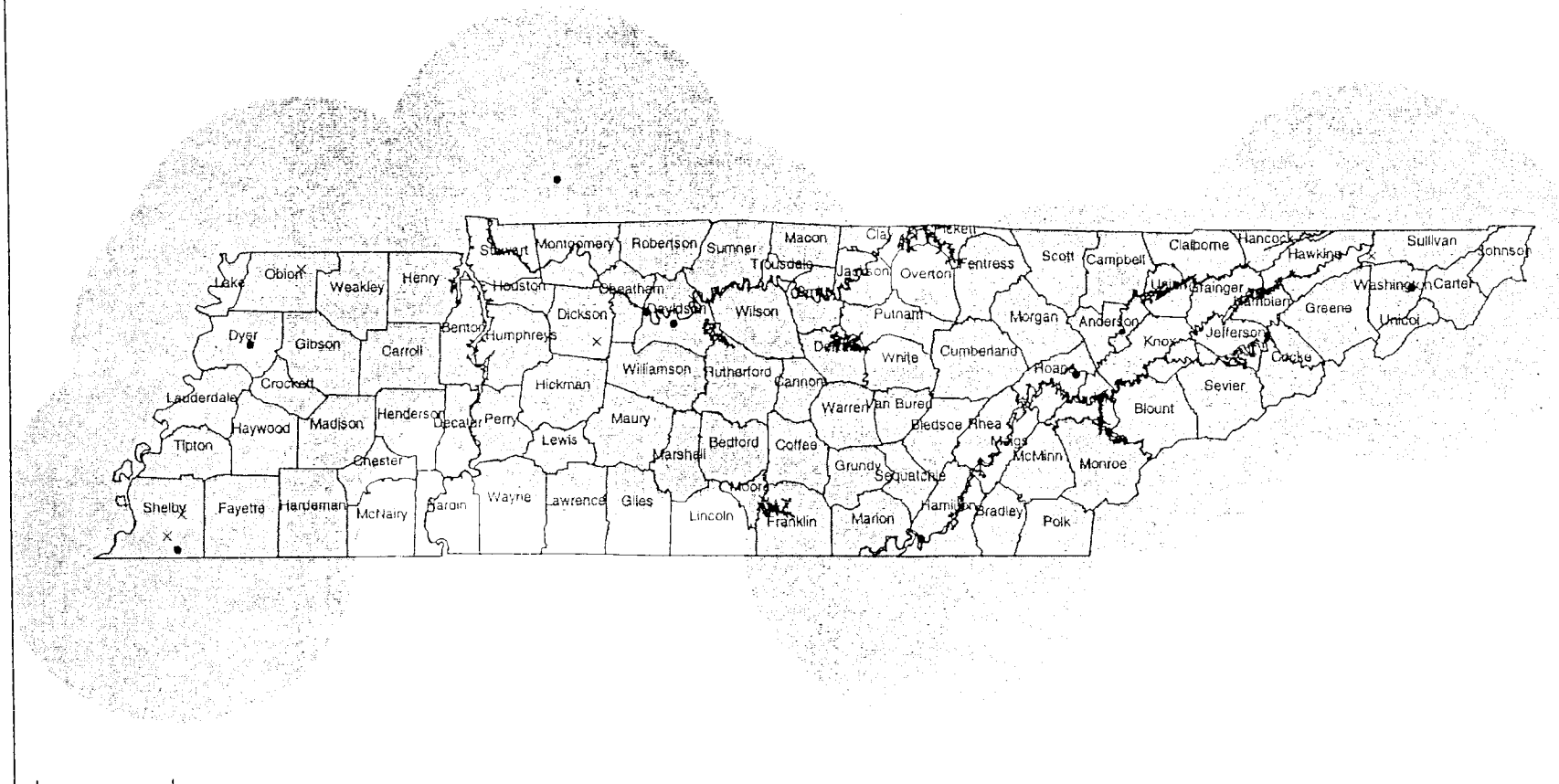
TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
MCNAIRY - TN			
ADAMSVILLE	38310	389	75.0
FINGER	38334	151	66.4
GUYS	38339	34	71.8
MICHIE	38357	153	77.9
MILLEDGEVILLE	38359	29	79.4
RAMER	38367	132	66.8
STANTONVILLE	38379	40	71.9
PUTNAM - TN			
COOKEVILLE	38506	1	68.8
VAN BUREN - TN			
ROCK ISLAND	38581	1	64.4
WARREN - TN			
MC MINNVILLE	37110	4	64.6
WAYNE - TN			
CLIFTON	38425	4	72.4
TOTALS		**5,502**	**74.3**

Provider group: TBH RTF 24 Hour Child - Facilities

Provider locations

TBH Substance Abuse Inpatient Child - Facilities



14 providers at 15 locations

- ● Single provider locations (8)
- × Multiple provider locations (7)
- ☐ 60 mile radius

ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
CHESTER - TN			
ENVILLE	38332	83	78.6
HENDERSON	38340	743	67.2
JACKS CREEK	38347	59	72.3
LURAY	38352	42	66.5
DECATUR - TN			
BATH SPRINGS	38311	41	73.6
DECATURVILLE	38329	213	69.8
GILES - TN			
GOODSPRING	38460	1	66.6
HARDIN - TN			
COUNCE	38326	104	86.8
CRUMP	38327	44	82.2
MORRIS CHAPEL	38361	85	84.4
OLIVEHILL	38475	84	80.0
PICKWICK DAM	38365	13	88.7
SALTILLO	38370	57	82.0
SAVANNAH	38372	1,679	87.8
SHILOH	38376	49	82.8
HENDERSON - TN			
DARDEN	38328	51	66.8
LEXINGTON	38351	785	66.2
REAGAN	38368	140	75.2
SARDIS	38371	79	81.5
SCOTTS HILL	38374	137	75.8
LINCOLN - TN			
FAYETTEVILLE	37334	2	71.8
MCNAIRY - TN			
ADAMSVILLE	38310	389	79.8
BETHEL SPRINGS	38315	261	66.3
FINGER	38334	151	71.0
GUYS	38339	34	73.3
MICHIE	38357	153	80.8
MILLEDGEVILLE	38359	29	83.0
RAMER	38367	132	69.9
SELMER	38375	514	67.5
STANTONVILLE	38379	40	76.7
PUTNAM - TN			
COOKEVILLE	38506	1	68.8

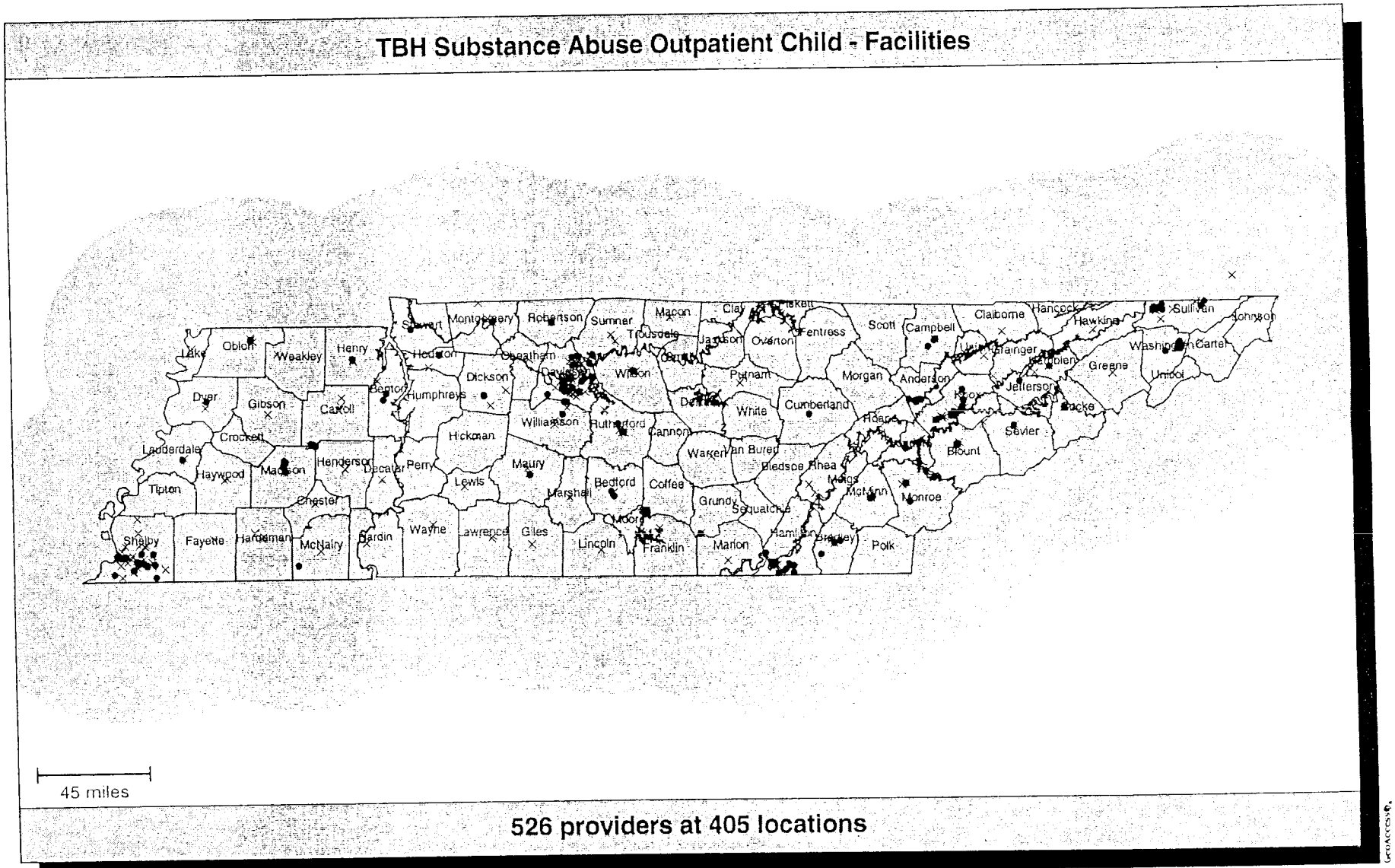
Provider group: TBH Substance Abuse Inpatient Child - Facilities

ZIP Code detail information

TBH Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
WAYNE - TN			
CLIFTON	38425	4	75.9
TOTALS		**6,199**	**76.1**

Provider group: TBH Substance Abuse Inpatient Child - Facilities

Provider locations



- Single provider locations (152)
- × Multiple provider locations (253)

☐ 60 mile radius

ZIP Code detail information

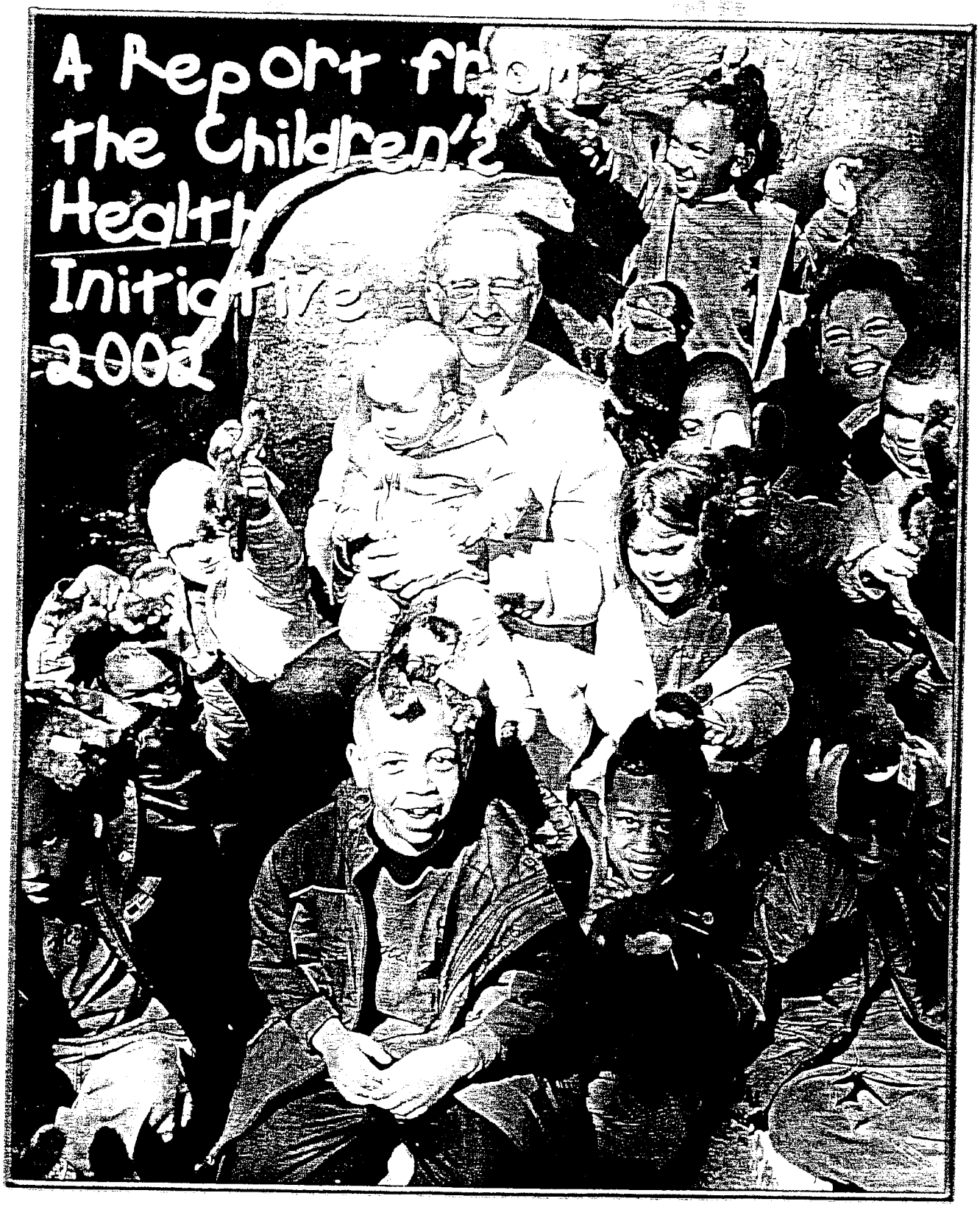
TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider

NO MEMBERS MEET THE SPECIFICATIONS

Provider group: TBH Substance Abuse Outpatient Child - Facilities

Tennessee Caring for Kids



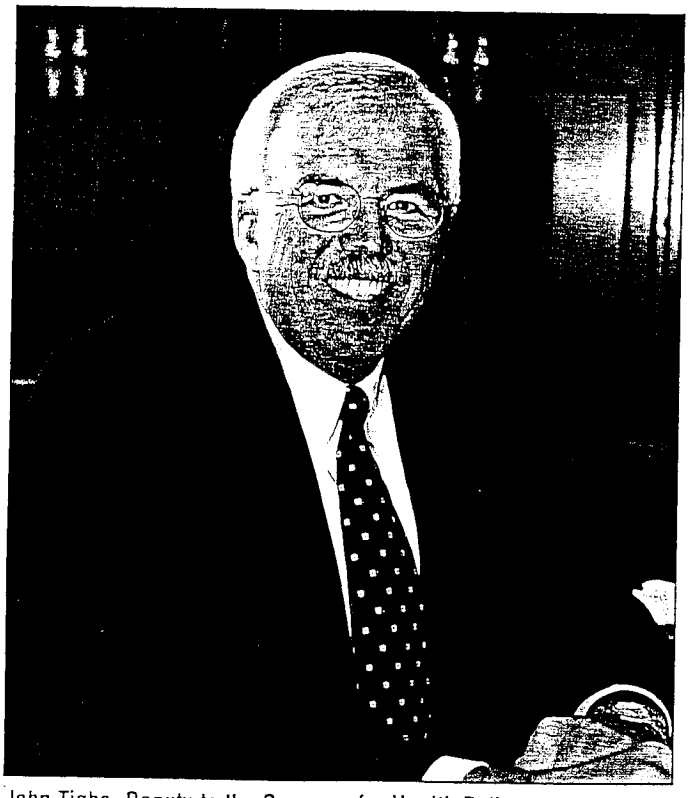
Reflections on the Past: Challenges for the Future

John Tighe, Deputy to the Governor for Health Policy

The future of our state depends on Tennessee children reaching their full potential by growing up healthy and happy. To that end, the Children's Health Initiative grew out of the realization by the Sundquist administration that in order to serve Tennessee's most vulnerable children in the most effective way, departments of state government needed to collaborate, integrate services, and most importantly, coordinate care for our children. Hence, in January of 2001, the Children's Health Initiative was begun under the leadership of Dr. Joe McLaughlin within the Office of Health Services. The team consists of three other members, including: Holly McDaniel, Outreach Coordinator; Mary Griffin, Compliance Attorney; and Dr. Patti van Eys, Coordinator of Mental Health Services.

TennCare, the state's Medicaid and expansion program for low income and uninsurable Tennesseans covers health insurance for 658,896 children as of March 2002. This coverage rate of 96 percent leads the nation in the percentage of children with access to health insurance and has resulted in significant improvements in outcomes such as:

- Marked increase in the number of well-child screenings;
- Higher immunization rates;
- Improved prenatal care;
- Better treatment for asthma;
- Lower emergency room use;
- Significantly improved dental care



John Tighe, Deputy to the Governor for Health Policy

In spite of these encouraging improvements, the Governor's health cabinet determined that much more could be done if we reduced the fragmentation of services between departments and set clear attainable goals. Those goals were:

- Increase the rates of medical, behavioral and dental screenings and treatment for TennCare children;
- Enhance compliance with, and coordination of, court orders and agreements related to children's healthcare services;
- Develop forums to bring together providers, families, advocates and state departments to collectively address concerns and improve services

Many accomplishments have been made toward these goals. Some changes are those of "process", such as bringing all the pertinent departmental commissioners to the table on a regular basis to find solutions for gaps in children's physical, behavioral, and dental health issues. Other changes reflect breakthrough advances for Tennessee's children, such as public-private partnerships resulting in increased access for physical and behavioral health care for children in state custody and significant strides in dental preventive care for children across the state. Whether big or

small, these collective efforts are making a real difference and illustrate what can be done by breaking down barriers and working together on behalf of Tennessee's children.

This report documents the variety of activities and services that have resulted from these collaborative efforts. In the report, you will find information on the various workgroups' targeted efforts to increase preventive screenings for all TennCare children, plans to serve our dually diagnosed children with mental retardation and behavioral health needs, testimonials illustrating our commitment to ensure that state custody is not the only option for parents to receive services for their children, a report to the community on the significant improvements in dental care for our TennCare children, and many more topics.

I hope that you enjoy reading this important report, and that by reflecting on what has been accomplished, together we can see future possibilities for all of us to work together to improve services to Tennessee's most vulnerable children.

Special thanks is given to the Commissioners' EPSDT Task Force, the Children with Special Health Needs Steering Panel, and the TennCare and Children Workgroup. Without the hard work and leadership of these individuals and to many more dedicated and committed individuals, the outcomes highlighted in this report would not be possible.

Commissioners' EPSDT Task Force

Pictured from left: **Page Walley, Ph.D.**, Commissioner, Department of Children's Services; **Natasha Metcalf, J.D.**, Commissioner, Department of Human Services; **Manny Martins,** Deputy Commissioner, Bureau of TennCare; **Fredia Wadley, M.D.**, Commissioner, Department of Health; **Richard Kellogg,** Deputy Commissioner, Division of Mental Retardation Services; **Joe McLaughlin, Ph.D., Chair,** Director, Children's Health Initiative; **John Tighe,** Deputy Commissioner, Deputy to the Governor for Health Policy. *Not pictured:* **Elisabeth Rukeyser,** Commissioner, Department of Mental Health and Developmental Disabilities; **Faye Taylor,** Commissioner, Department of Education

The Children's Health Initiative

Pictured from left: Holly McDaniel, Joe McLaughlin, Ph.D., Mary Griffin, J.D., Patti van Eys, Ph.D.

"The Steering Panel has provided a forum to identify barriers to services for children with special health needs. But more importantly, it has allowed public and private health providers and state department representatives to discuss possible ways to tear down the barriers and start developing a system that is more responsive to children and their families. Advocates, mental health professionals, private pediatricians, as well as specialty physicians from tertiary children's hospitals have devoted a great deal of time to this Panel just to make the lives of children better in Tennessee".

Fredia Wadley, M.D., Commissioner of Health

Children with Special Health Needs Steering Panel

Fredia Wadley, M.D., Chair
Commissioner, Department of Health
Nashville, Tennessee

Billy Arant, M.D.
T.C. Thompson Children's Hospital
Chattanooga, Tennessee

Robert Atkins, M.D.
Associate Medical Director for Behavioral Health
Schaller-Anderson of Tennessee
Nashville, Tennessee

Susie Baird, M.Ed.
Director of Program Development, Bureau of TennCare
Nashville, Tennessee

Jeanie Beauchamp, D.D.S.
Pediatric Dentist, Clarksville Pediatric Dentristry
Clarksville, Tennessee

Gordon Bonnyman, J.D.
Managing Attorney, Tennessee Justice Center
Nashville, Tennessee

Charlotte Bryson
Executive Director, Tennessee Voices for Children
Nashville, Tennessee

Susan Burkett, RN, MSN, CPNP, CPN
Administrator, T.C. Thompson Children's Hospital
Chattanooga, Tennessee

Thomas Catron, Ph.D.
Co-Director, Vanderbilt University Center of Excellence
Nashville, Tennessee

Joseph Childs, M.D.
Vice President, Medical Services
East Tennessee Children's Hospital
Knoxville, Tennessee

Patricia Davis, M.D.
Pediatrician, Columbia Pediatrics
Columbia, Tennessee

Eula Dowdy
Foster Parent
Clarksville, Tennessee

Larry Faust, M.D., FAAP
Director, Implementation Team, Department of Health
Nashville, Tennessee

Dennis Freeman, Ph.D.
Chief Executive Officer, Cherokee Health Systems, Inc.
Talbott, Tennessee

Kacie Fitzpatrick, MA
Child Health Advocate, Implementation Team, Department of Health
Nashville, Tennessee

Linda Fry, CMSW
Coordinator, Center of Excellence
T.C. Thompson Children's Hospital
Chattanooga, Tennessee

Mary Griffin, J.D.
Compliance Attorney, Tennessee Children's Health Initiative
Nashville, Tennessee

Mary Jo Heimbigner, MSW
Social Worker, Implementation Team, Department of Health
Nashville, Tennessee

Jerry Heston, M.D.
Director, Division of Child Psychiatry
UT College of Medicine
Memphis, Tennessee

Gerald Hickson, M.D.
Co-Director, Vanderbilt University Center of Excellence
Nashville, Tennessee

Quentin Humberd, M.D.
Pediatrician, Premier Medical Group
Clarksville, Tennessee

Melissa Isbell
Network Development Manager, Advocare of Tennessee
Nashville, Tennessee

Michele Johnson, J.D.
Staff Attorney, Tennessee Justice Center
Nashville, Tennessee

Carla McCord
Executive Secretary, Implementation Team
Department of Health
Nashville, Tennessee

Holly McDaniel
Outreach Coordinator, Tennessee Children's Health Initiative
Nashville, Tennessee

Joseph McLaughlin, Ph.D.
Director, Tennessee Children's Health Initiative
Nashville, Tennessee

Tom Mitoraj, M.D.
Pediatrician, Youth Care Pediatrics
Bristol, Tennessee

David Moroney, M.D.
Medical Director, TennCare Services
Blue Cross Blue Shield of Tennessee
Chattanooga, Tennesee

Michael Myszka, Ph.D.
Psychologist with the Office of Medical Director
Bureau of TennCare
Nashville, Tennessee

Linda O'Neal, J.D.
Executive Director
Tennessee Commission on Children and Youth
Nashville, Tennessee

Frederick Palmer, M.D.
Director, UT Boling Center for Developmental Disabilities
Memphis, Tennessee

Andres Pumariega, M.D.
Director, ETSU Center of Excellence
Johnson City, Tennessee

Judy Regan, M.D.
Medical Director, Department of Mental Health and Developmental Disabilities
Nashville, Tennessee

Linda Ross, J.D.
Deputy Attorney General, Office of the Attorney General and Reporter
Nashville, Tennessee

Clifford A. Seyler, M.D.
Pediatrician, Tullahoma Pediatrics
Tullahoma, Tennessee

Jacqueline Shaw, M.D.
Pediatrician, Family Health Services
Chattanooga, Tennessee

Laura Stewart, J.D., MTS
Executive Assistant to the Commissioner
Department of Children's Services
Nashville, Tennessee

William Terrell, M.D.
Pediatrician, Memphis and Shelby County Pediatric Group
Memphis, Tennessee

Larry Thompson, Ph.D.
Deputy Director, Office of Managed Care, Department of Mental Health and Developmental Disabilities
Nashville, Tennessee

Patti van Eys, Ph.D.
Mental Health Coordinator
Tennessee Children's Health Initiative
Nashville, Tennessee

Ellyn Wilbur, MPA
Vice President, TennCare Partners II, Advocare of Tennessee
Nashville, Tennessee

Diana Yelton, CMSW, MA
Program Healthcare Advocacy
Tennessee Department of Children's Services
Nashville, Tennessee

Paul Demuro
Consultant
Montclair, New Jersey

TennCare and Children Workgroup

Joseph McLaughlin, Chair
Tennessee Children's Health Initiative

Pam Brown
Tennessee Commission on Children and Youth

Mary Griffin
Tennessee Children's Health Initiative

Tony Halton
Tennessee Homeless Coalition

Dara Howe
Family Voices of Tennessee

Amy Jackson
Tennessee Healthcare Campaign

Kacie Fitzpatrick
Implementation Team, Department of Health

Holly McDaniel
Tennessee Children's Health Initiative

Louise Morris
Tennessee Healthcare Campaign

Connie Nelson
Tennessee Voices for Children

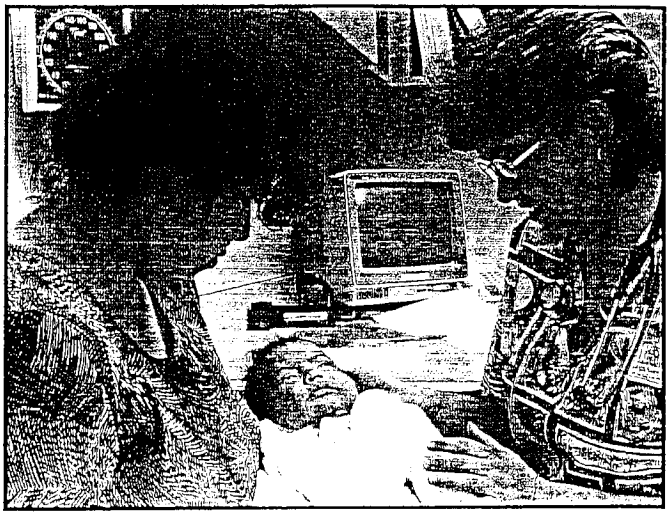
Patti van Eys
Tennessee Children's Health Initiative

EPSDT Screening Rates Improvements

EPSDT is an acronym that has been repeated continuously among child-serving state agencies in the last several years. EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. EPSDT is a Medicaid entitlement for Medicaid enrollees ages birth to 21. EPSDT includes well child screening as well as diagnostic evaluations and treatment for medically necessary services. The original concept behind EPSDT was to emphasize preventive health efforts so that children have the best chance of maximizing their developmental potential.

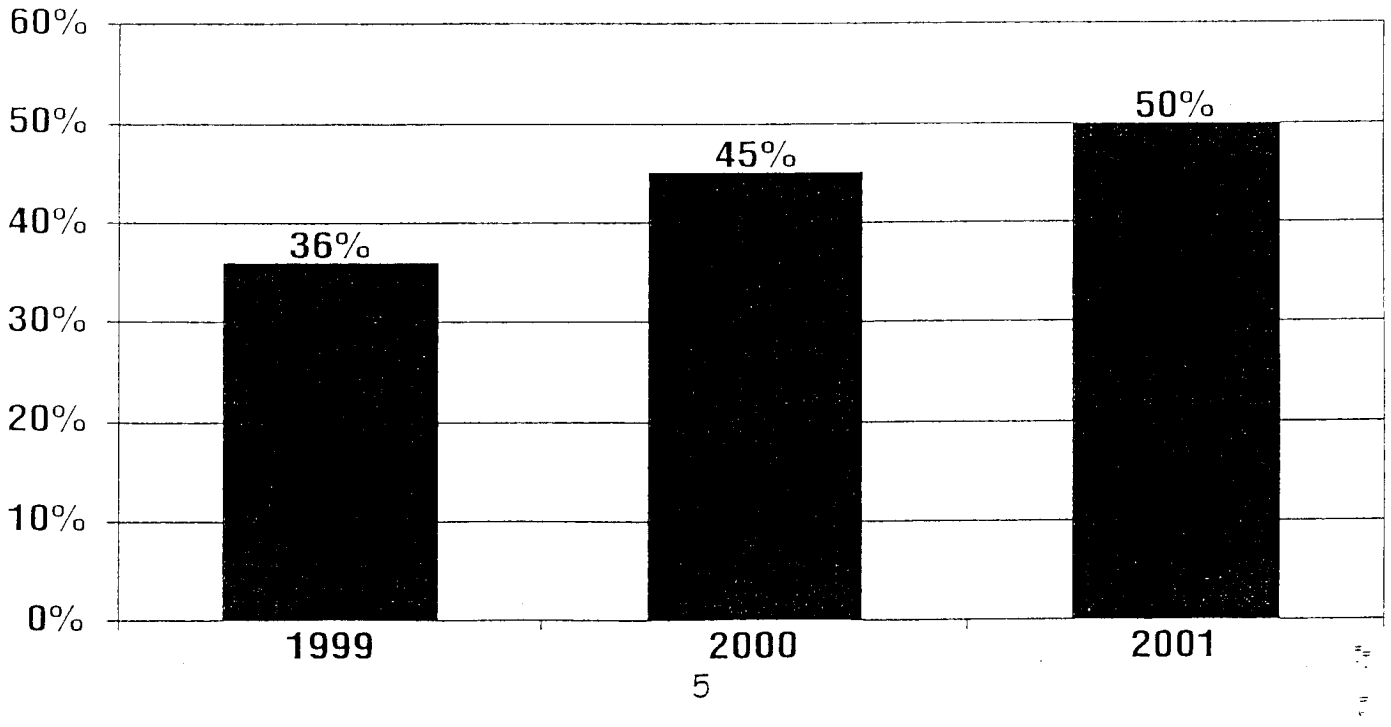
In Tennessee, much effort has been put into raising the EPSDT screening rates for TennCare enrollees under age 21. These well-child check-ups, based on the American Academy of Pediatrics periodicity schedule, have risen in Tennessee over the last two years. These rates are rising due to a combination of efforts including: 1) the renewed activity of the Health Departments; 2) the public awareness campaign; 3) the partnering between TennCare and the Tennessee chapter of the American Academy of Pediatrics; 3) provider education; and 5) the creation of TennCare Select.

The Children's Health Initiative has been an active partner in all of these efforts that are described in detail in the following pages. While the rising EPSDT screening rates are a step in the right direction, continued collaborative efforts are essential in order to reach our goal of 80%.



Shelnessa Cole, RN, PHN4, advises a mother on her infant's health during an EPSDT exam at the Wilson County Health Department.

CMS 416 EPSDT Screening Percentage



Public Health EPSDT Activities

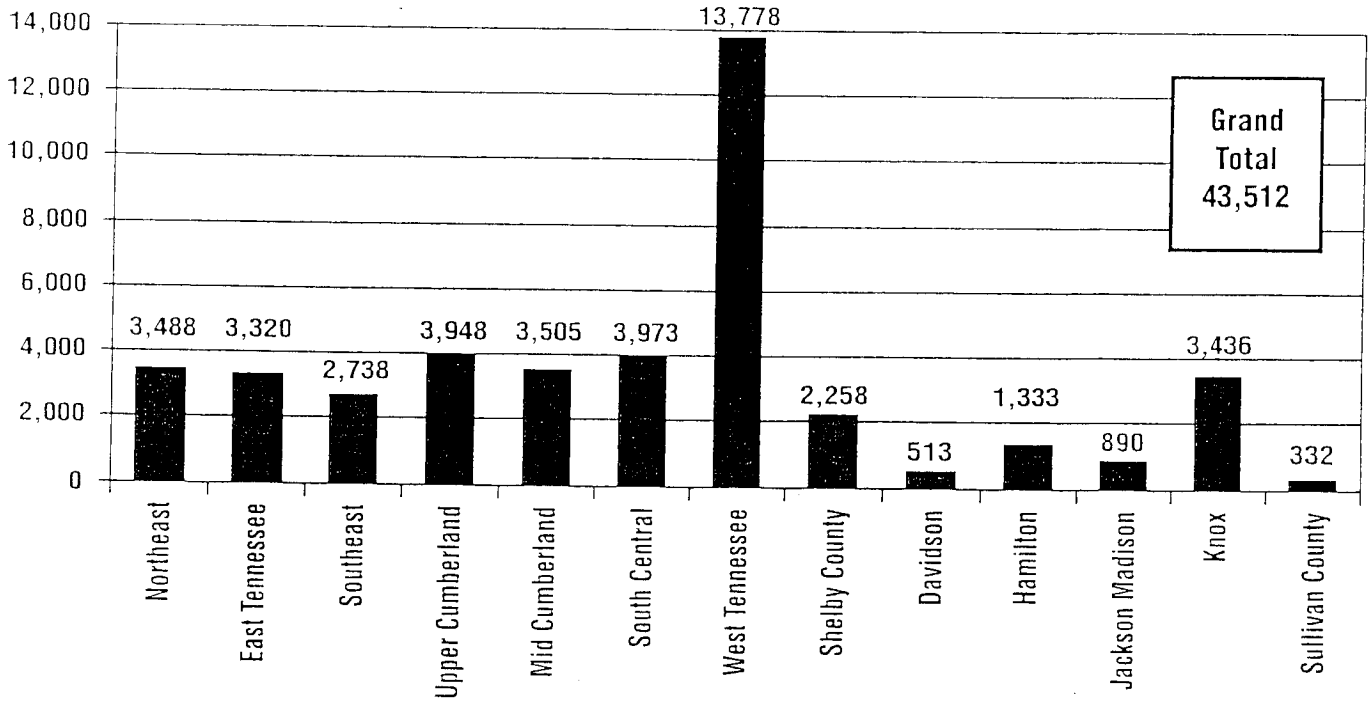
In an effort to boost EPSDT screening rates for TennCare eligible children, the Bureau of TennCare entered into a contract in 2001-2002 with the Department of Health to perform EPSDT screens. Local health departments, serving each of the 95 Tennessee counties, offer accessible venues for well-child screens, particularly in rural areas where there is a limited number of child health specialists. Regionally, Health Departments have initiated innovative outreach efforts that are paying off. This vital resource, with EPSDT services under the leadership of Dr. Wendy Long and Annette Goodrum, RN, has already proven its worth by performing 43,512 screens in the past fiscal year (7/0/01-6/30/02), with an average of 5,000 a month in the last six months of this time period. The Health Department staff are obtaining solid training on the physical assessment components of EPSDT through courses at Belmont and Union Universities and traveling faculty from East Tennessee State University. Additionally, nurses received in-depth training on the importance of completing and documenting all seven required components of the EPSDT screen.

Below are the statistics by county of the health department screenings in this first year of operation.

- Complete health history including developmental and behavioral screening;
- A complete physical exam;
- Lab work;
- Immunizations;
- Anticipatory guidance and health education;
- Hearing screening;
- Vision screening

Health Department EPSDT Screenings

July 1, 2001 - June 30, 2002



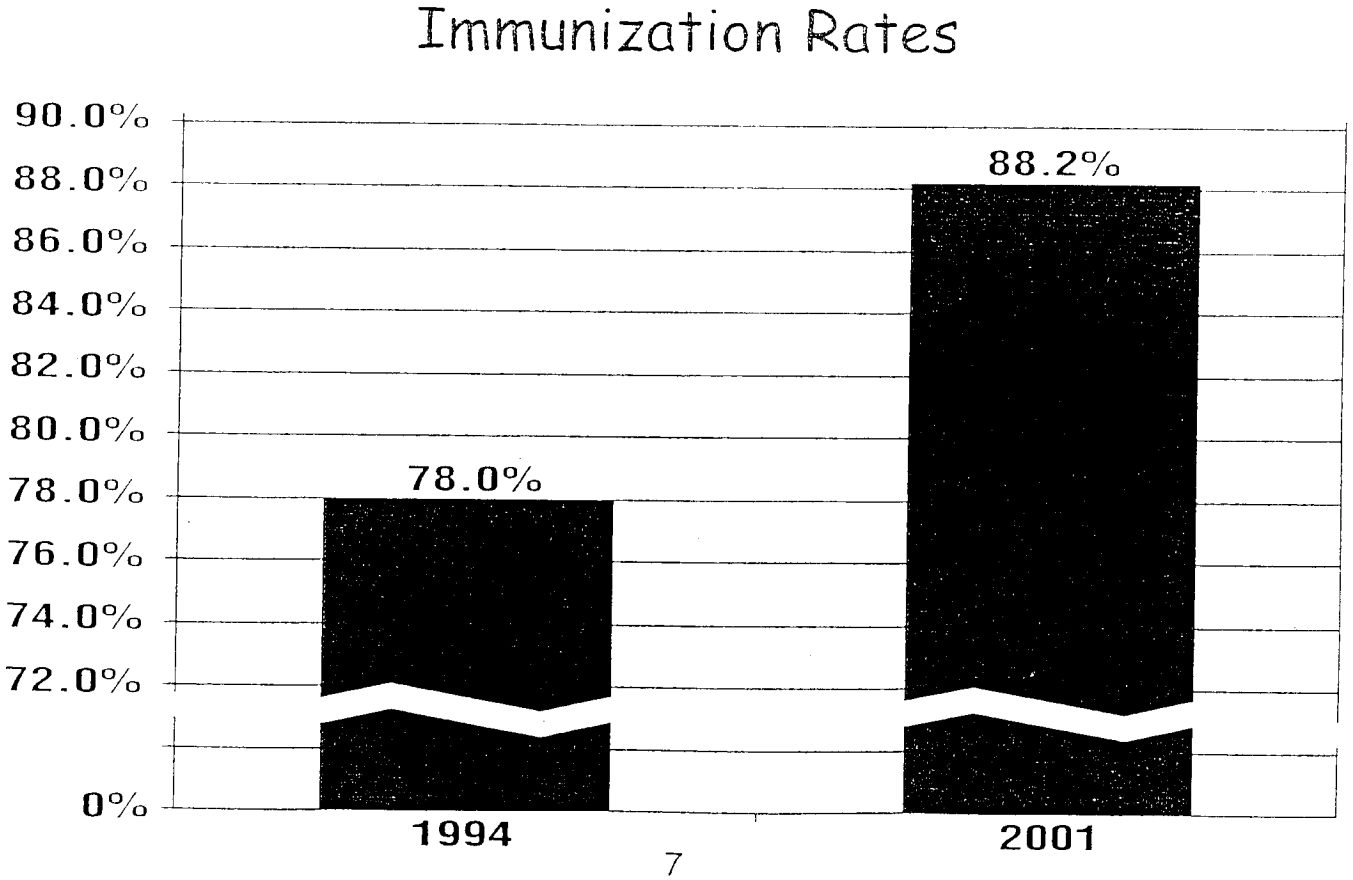
Shelnessa Cole, R.N., PHN4, performs an EPSDT exam at the Wilson County Health Department.

Many local Health Departments are conducting regular meetings with MCOs, DCS, and Head Start staff to promote screenings.

West Tennessee has developed a "missed opportunity" report that tracks children who access WIC or immunization services but did not receive an EPSDT screen. These missed children are sought out for their screens.

One component of the EPSDT screen is immunization. Immunization rates, seen federally as a way to measure the health of children, have risen dramatically under the Sundquist administration. The state reached an all-time high immunization rate in 2001; 88.2 percent of all two-year-olds in the state received all of the recommended vaccinations against seven diseases: measles, mumps, rubella, pertussis, tetanus, diptheria and polio. These figures compare to a 78 percent immunization rate in 1994.

While TennCare as a program has helped to boost immunization levels due to its broad coverage for children, Dr. Fredia Wadley, Commissioner of Health, has implemented additional aggressive measures to raise immunization rates since 1995. She views vaccines as "the most powerful and cost-effective way to prevent infectious diseases in children." The state's initiatives have included implementing an immunization registry to send reminders to parents when immunizations are due; creating private partnerships to increase public awareness; sending a congratulatory card including important immunization information from First Lady Martha Sundquist to each new mother in Tennessee; requiring Families First participants to have their children immunized



Staff of many local health departments are meeting with private physicians to facilitate the coordination of EPSDT exams.

Upper Cumberland is placing pamphlets in children's clothing stores, consignment stores, Goodwill, and other retail locations.

Northeast Region has established an effective tracking system that contacts families when the next EPSDT exam is due.

Mid-Cumberland Region is linking WIC and EPSDT. WIC vouchers are given for one month and an EPSDT screen is scheduled. The family must come for the screen in order to gain additional WIC vouchers.

Regions have developed brochures and conducted newspaper interviews to promote EPSDT.

as a condition of participation; working through the Women, Infants and Children (WIC) nutritional program to improve the immunization status of program participants, and implementing the Vaccines for Children program in Tennessee that provides $8.5 million worth of vaccines to private physicians for eligible children each year.

"Some of the problems we have identified through EPSDT exams include hearing problems, dental decay, heart murmurs, speech delays and behavioral disorders.... Referring these children early for treatment has given them a better chance for healthy lives."

Shelnessa Cole
Nursing Supervisor
Wilson County Health Department

Right: Fredia Wadley, M.D., Commissioner of Health *Below Left:* Wendy Long, M.D., MPH with Stephanie Hewgley, a nurse practitioner at the Williamson County Health Department.

"Local health departments in every county of the state are now actively involved in the delivery of EPSDT screens and health department staff performed over 43,000 EPSDT screens in the first year of operation. Far more important than statistics, though, are the stories of individual children whose lives have been changed for the better because of early identification and treatment of health care problems. I have the great fortune to hear such stories on a regular basis from dedicated public health nurses and physicians throughout the state. I am very grateful for the role the Children's Health Initiative played in making these services a reality."

Wendy Long, MD, MPH
Health Services Administration

EPSDT Public Awareness Campaign:
Tennessee Caring for Kids

"Thanks for the Care you Give" is a slogan you may have heard on radio or television in the past year. *Tennessee Caring for Kids* is a slogan that may have caught your eye on the wall of your child's school. On September 15, 2001, TennCare entered into a contract with StagePost Film, Video, and Post Production to launch an EPSDT Public Awareness Campaign. A nine member steering committee, comprised of representatives from the Department of Health, Bureau of Tenncare, Children's Health Initiative, and Tennessee Chapter of the American Academy of Pediatrics worked to create a logo, a theme, and a design for the campaign. The workgroup consulted with advocates to ensure that the materials were appropriately informative for the TennCare enrollee population.

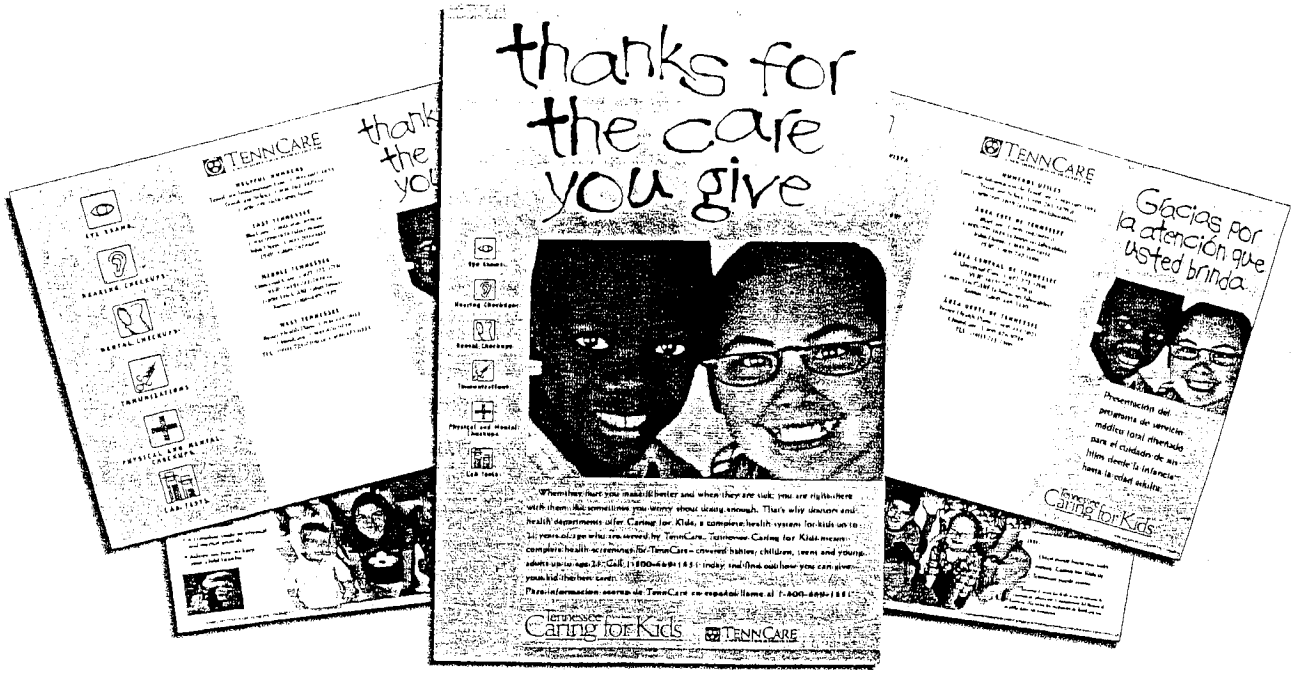
Materials were produced in both English and Spanish versions. In addition to radio and television spots, brochures and posters were disseminated. These materials included information explaining the scope and schedule of **Early and Periodic Screening, Diagnosis and Treatment** (EPSDT) check-ups and helped to translate the awkward federal language into simple "well-child check-up" language. Additionally, the materials clarified easy access to these services.

The printed information was distributed to all members of the Tennessee Chapter of the American Academy of Pediatrics, county Health Departments, Department of Human Services, managed care companies, and advocacy groups. Also, several thousands of brochures were sent to TennCare enrollees as a result of a telemarketing campaign designed by the workgroup.

> *"I distributed Tennessee Caring for Kids Brochures in our Early Child Health Outreach packets in five EPSDT trainings this year. The trainings were for primary care providers, day care providers, social workers, and parents and relative caregivers with children on TennCare. The brochures were colorful and easy to understand for those we trained. I especially like the icons for each of the seven components of an EPSDT screen."*
>
> Amy Jackson,
> Program Director of ECHO (Early Child Health Outreach)

This public awareness campaign, in the end, will have run a statewide media campaign and will have distributed:

- 760,000 English EPSDT brochures;
- 110,000 Spanish EPSDT brochures;
- 10,000 Posters



Tennessee Chapter of the American Academy of Pediatrics

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) entered into a contract with the TennCare Bureau on July 1, 2001, to work with the state to improve the quality and quantity of EPSDT screenings and other child health services. TNAAP has been involved in the EPSDT Workgroup, a collaboration of the MCOs and the TennCare Bureau under the leadership of Dr. Conrad Shackleford, to improve outreach and coordination in the provision of EPSDT services, as well as continuing to meet regularly with the Children's Health Initiative and the Department of Health to plan child health service improvements.

TNAAP members were involved in the development and review of the *"Tennessee Caring for Kids"* EPSDT Provider Video and CyberCE on-line educational sessions for Primary Care Providers. TNAAP has also been actively involved in the development of the EPSDT public awareness campaign "Tennessee Caring for Kids" materials (poster, brochures, TV and radio spots).

TNAAP has provided leadership in clarifying appropriate use of CPT (billing) codes both to provide accurate data about services and to support appropriate reimbursement of providers. TNAAP conducted focus groups with physicians to assess barriers to care and physician participation in TennCare.

TNAAP has also led the way in making revisions in the age-specific, well child forms recommended for use in EPSDT screening visits. As was the case with the previously disseminated set of well child forms developed by TNAAP, the revised forms serve as prompts for health care professionals to provide the full complement of EPSDT screening services appropriate to each age group and provide a convenient means of documenting these services. The revised forms are available on the TNAAP web site (www.aap.org) and on the TennCare web site (http://www.state.tn.us/tenncare). TNAAP, the MCOs, and the TennCare Quality Oversight division are also distributing the forms.

TNAAP took a leadership role in a Medical Home Planning Project designed to educate providers and communities about implementation of the Medical Home concept. The Medical Home model ensures that each child patient has a medical provider with primary responsibility for his or her individual care and has the full set of medical records so that health care can be optimally planned and coordinated. For example, a child in the foster care system who may be moved from one placement to another would have continuous health care if he or she had a consistent medical home.

Dr. Lloydetta Stovall, member of the Tennessee Chapter of the American Academy of Pediatrics, performs EPSDT screens at a Health Fair (sponsored by state Senator Roscoe Dixon) in Memphis, July 2002.

photo courtesy of The Memphis/Shelby County Medical Society taken by Janice Cooper, Executive Assistant

Numerous EPSDT-related articles have been published in the TNAAP newsletter. TNAAP also established dialogue with the Tennessee Academy of Family Physicians (TAFP) regarding TNAAP's EPSDT activities and made the newsletter articles available to them for publication in the TAFP newsletter. TNAAP has continued to serve as a resource to the state for information on the most current national standards related to pediatric care and national coding practices and trends, such as the recent trend to begin reimbursing separately for hearing and vision screens. Also, a TNAAP representative and a Health Department representative now act as liaisons to address physician concerns that arise related to the Health Departments providing EPSDT screens.

Additional TNAAP efforts for fiscal year 2002-2003 will include: 1) education of primary care providers at practice sites about both EPSDT services and coding; and 2) participation in the feedback process with providers after the audits conducted by the TennCare Quality Oversight division.

F. Joseph McLaughlin, Ph.D., director of the Children's Health Initiative, receives the 2002 Friend of Children Award from the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). Joseph F. Lentz, M.D., TNAAP's Immediate Past President and recipient of the 2002 Pediatrician of the Year Award, accompanies him.

"The Children's Health Initiative is highly valued by Tennessee pediatricians. By bringing together providers and many of the pertinent state agencies, it provides a single coordinated point of contact for children's issues impacted by TennCare. Thanks to the Children's Health Initiative, we feel that our voice is better heard."

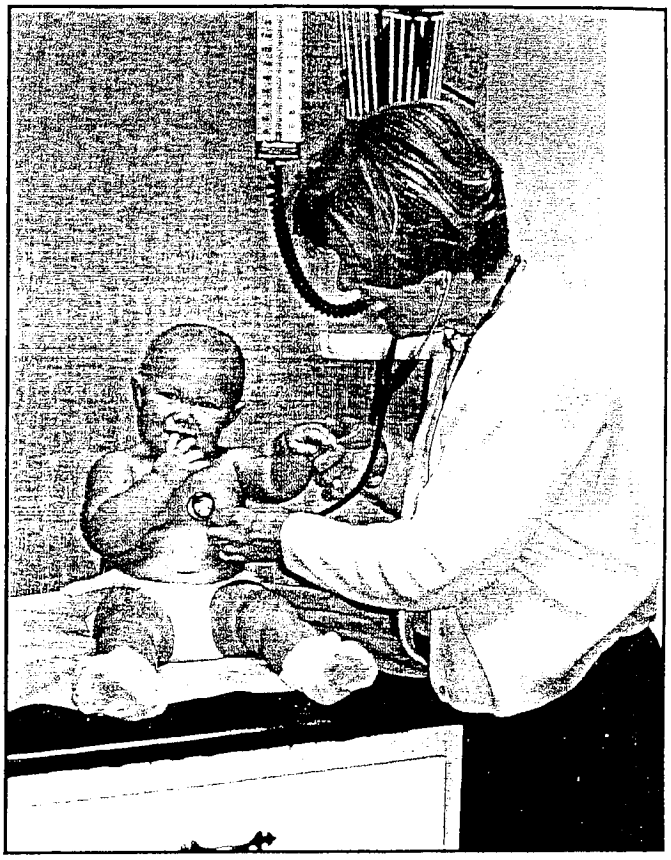
Dr. John C. Ring, President
Tennessee Chapter of the American Academy of Pediatrics

Provider Education Efforts

The Tennessee Children's Health Initiative has created and distributed an EPSDT (Early and Periodic Screening, Diagnosis and Treatment) provider training video entitled "Tennessee Caring for Kids: EPSDT Provider Video." This 16 minute, educational tool shows the seven components of a well-child physical (EPSDT screen) as well as the appropriate accompanying billing codes. Created and edited by Dr. Joe McLaughlin, Dr. Michael Myszka, Dr. Conrad Shackleford, Dr. David Moroney, Dr. Joel Bradley, Holly McDaniel and representatives from the Tennessee Chapter of the American Academy of Pediatrics, the video was produced by The University of Tennessee Center for Industrial Services.

A packet of information accompanies the video and includes:

- Information regarding childhood lead poisoning and screening questions in seven languages;
- Copies of age-specific well child visit forms;
- Chlamydia screening guidelines;
- Anticipatory guidance information from Bright Futures;
- Tuberculosis risk assessment questionnaire in seven languages;
- American Academy of Pediatrics periodicity chart;
- A description of the medical home concept;
- EPSDT guidelines for:
  - Hearing
  - Vision
  - Development
  - Behavioral/emotional issues



Dr. Patricia Davis, TNAAP EPSDT Medical Director, performs an EPSDT screen at her office in Columbia, Tennessee.

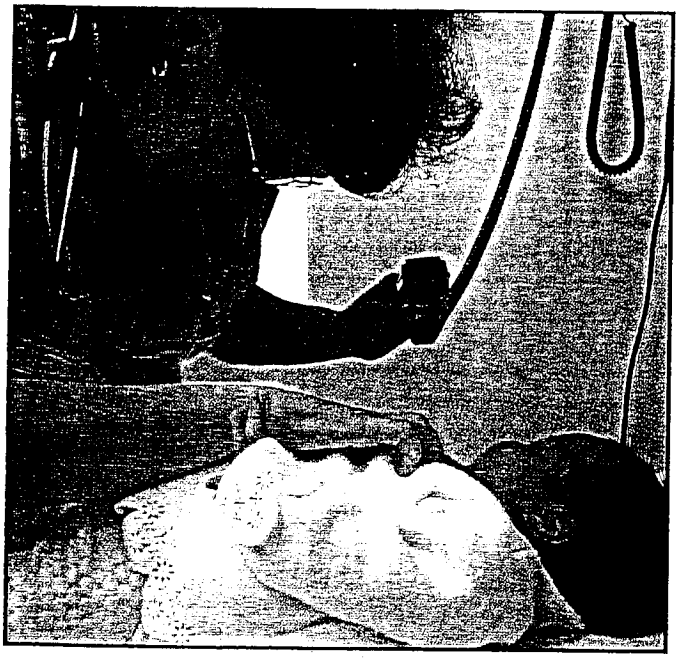
"The Quality Oversight Division has found the use of the recently produced videos very useful in the education of providers on the various elements of the EPSDT well-child screens. When we visit provider offices to perform medical record audits, the video is either played for the provider and staff or left with the office for future viewing. As a whole, the feedback from locations visited indicates that the tapes and accompanying forms are very useful in improving understanding of the EPSDT requirements."

Ken Okolo,CPHQ, FACHE
Director of Quality Oversight, Bureau of TennCare

Approximately 4,500 videos and materials have been distributed to providers and health care organizations, including: primary care providers (family doctors, pediatricians, nurses); Health Departments; Even Start programs; Head Start Programs; Managed Care Organizations; health-related professional schools; and health care advocacy groups.

This high quality, informative video has received positive reviews from the field. In addition to this video educational outreach effort, the Tennessee Children's Health Initiative has led numerous trainings regarding children's physical, mental, and dental health care needs. Such trainings have included:

- Annual juvenile court judge's conferences;
- Advocare provider trainings;
- Tennessee Association of Mental Health Organization Child and Youth subcommittee meetings;
- Tennessee Voices for Children Board meetings;
- Tennessee Voices State of the Child Conference 2002 and Annual Convention;
- Community Services Agency Family Crisis Intervention Team;
- Children with Special Health Needs Conference;
- Policymakers' Discussion on Children's Health ;
- TennCare Partner's Roundtable Children and Youth committee;
- Tennessee Commission on Children and Youth Children's Advocacy Days 2002;
- Tennessee Chapter of the American Academy of Pediatrics meetings;
- Tennessee Conference on Social Welfare;
- Tennessee Association of Mental Health Organization Annual Conference



Shelnessa Cole, R.N., PHN4, performs an EPSDT exam at the Wilson County Health Department

"The Children's Health Initiative has been a great partner in the first two annual Policymakers' Discussions on Children's Health. I think ideas that have come up at the Policymakers' Discussion have been useful in trying to bring up EPSDT screening rates and it is great that they've been there to help foster a positive environment of discussion and to act on solutions as well as barriers to care for children."

Amy Jackson, Program Director, Early Child Health Outreach (ECHO)

In addition, efforts have been made to develop on-line educational resources for providers, both through the contract with the on-line educational services company, CyberCE, and by additions to the TennCare web site (http://www.state.tn.us/tenncare). The TennCare web site includes information on screening guidelines, recommended age-specific well child forms, a link to the Pediatric Symptom Checklist (a validated behavioral health screening instrument), information on immunization, and Health Department information.

"We can always count on the staff at the Children's Health Initiative to present professional, objective and comprehensive reports on children's health policy and strategy. It is clear that the CHI's agenda is to improve children's health. We all appreciate their openness and clear dedication to their mission."

Charlotte Bryson, Executive Director, Tennessee Voices for Children

TennCare Select

TennCare Select, born out of a need for a "back-up" health care plan, was formally initiated in July 2001. The Sundquist administration realized that if Managed Care Organizations (MCOs) failed financially, reached capacity, or simply needed a "breather" in terms of capping the number of enrollees for a time period, the enrollees should not suffer and providers of "overflow" health care must always be paid. Thus, the need for a statewide back-up system that would be deep enough to handle both overflow capacity and special populations was a must. Of significant concern was the population of vulnerable children - those in state custody, at risk of state custody, or with extremely complex health care needs. Federal advisors were asking states to determine if a managed care model was the best model for such children. TennCare Select was developed to serve as a non-managed care model that could test out whether children with complex needs are indeed better served under a "state-at-full-risk" model.

In January 2000, the Governor appointed the Commission on the Future of TennCare. This group obtained feedback from providers, advocates, and consumers from regions across the state in order to gain perspective on the design needs for TennCare Select. The commission agreed that a "one size must fit all" model was inappropriate for special needs children and fully endorsed a different model.

That model included the involvement of one MCO contractor, BlueCross BlueShield of Tennessee (BCBST), through its Volunteer State Health Plan subsidiary. Since July 2001, BCBST has operated as the administrator of the TennCare Select MCO, or TennCare's state-owned "safety-net MCO". TennCare Select enrollment includes several different definable populations. These populations include 11,666 Department of Children's Services (DCS) enrollees and 30,188 Supplemental Security Inome (SSI) recipients that are eligible for EPSDT services. TennCare Select enrollment also includes a general population ("overflow population") of 218,065 individuals, of which 100,037 are eligible for EPDST. [1] Together, approximately 141,891 of the TennCare Select enrollees are children.

"TennCare Select has been wonderful. Not only has moving to a single MCO for children in state custody greatly simplified the system for our case managers, but the employees at Blue Cross Blue Shield consistently do everything they can to assist us."

Laura Stewart, Assistant to the Commissioner, Department of Children's Services, Health Care Advocacy

"I think the TennCare Select model is important because it connects the special-needs child with one contractor which reduces the hassles for the family, individual and the provider, leading to better health care service."

John Tighe, Deputy to the Governor for Health Policy

When one MCO closed in late 2001, a smooth transition allowed for the continuous uninterrupted care for child members, demonstrating the usefulness of TennCare Select as a safety net.

In establishing TennCare Select, the Bureau of TennCare placed special emphasis on the needs of children in state custody or at risk of entering state custody ("DCS enrollees"). Accordingly, the TennCare Select contract between TennCare and BCBST defines specific requirements for MCO services for this special-needs population. Consistent with the contract, BCBST has developed a special TennCare Select Primary Care Provider (PCP) network, the Best Practice Network, or BPN, which includes over 650 PCPs statewide. The BPN PCP agrees to provide comprehensive primary care services for TennCare Select DCS enrollees and to establish a "medical record home." The BPN PCP also participates in clinical quality improvement activities with the goal of improving access to, and coordination of, comprehensive medical and behavioral services for DCS enrollees.

To support the BPN, BCBST has committed substantial administrative resources to provider support, member services, and interagency coordination services. A dedicated BPN Unit has been established to support the operations of TennCare Select for DCS enrollees. This unit works closely with DCS, foster families, BPN providers, Centers of Excellence, BCBST medical management, the BHO, and others to ensure timeliness and coordination of EPSDT services. To help improve access to EPSDT services for children entering state custody, the Bureau of TennCare approved for TennCare Select and DCS to coordinate for children to receive 45 days of "Immediate Eligibility" in TennCare Select upon entering custody. This 45-day period allows these children to receive EPSDT screenings and other medically necessary services while they go through the formal TennCare Eligibility process.

[1] Enrollment figures as of September 23, 2002

Children's Oral Disease Prevention Services

Great improvements in children's dental care were achieved in 2001-2002. The Children's Oral Health Planning Group, chaired by the Children's Health Initiative, comprised of dentists, dental specialists, and interagency state staff representatives, focused on three major thrusts to improve dental services for children: 1) a "carve-out" of dental services under TennCare; 2) the School-Based Dental Prevention Project by the Department of Health and 3) involvement and support of organized dentistry to promote and encourage participation of dentists as providers in the dental carve-out.

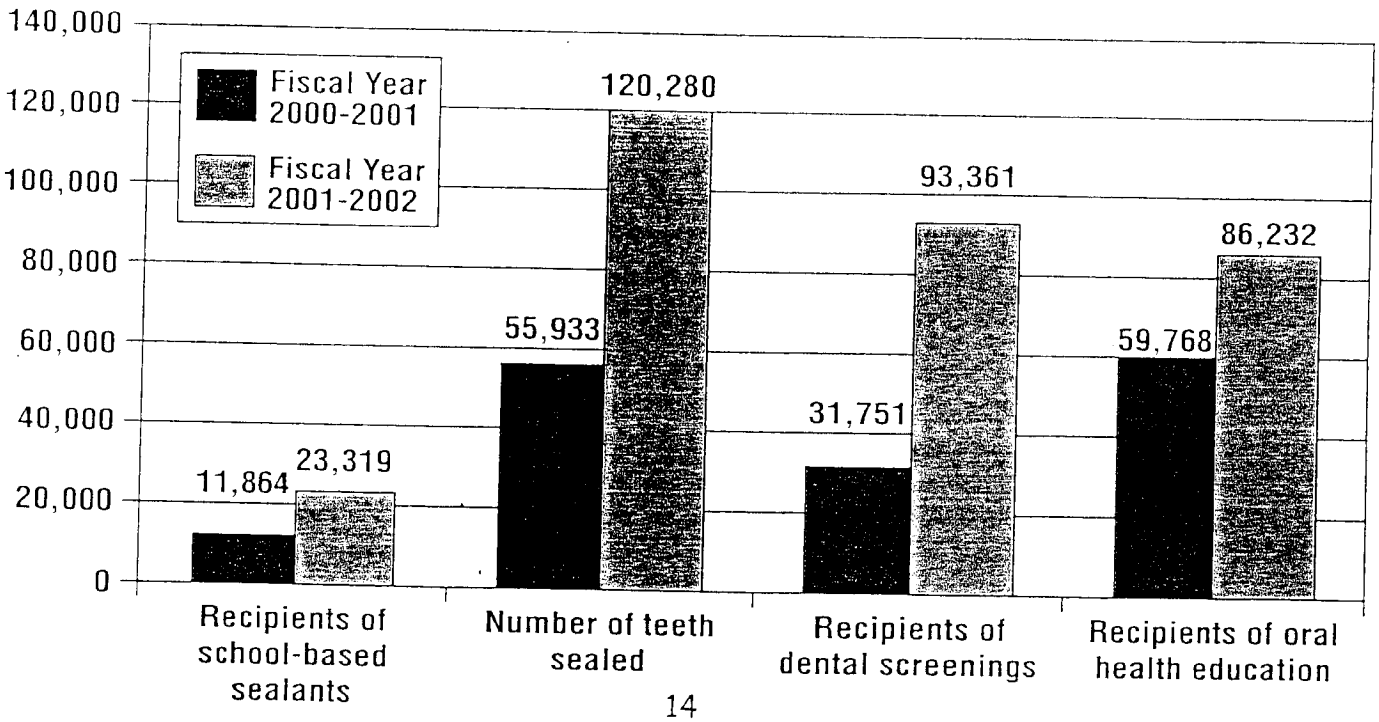
The dental carve-out, which became operational October 1, 2002, has a single dental benefits manager, Doral Dental Services, and has attracted a larger number of dentists into the provider network. Professional associations of dentists, such as the Tennessee Dental Association and the Pan Tennessee Dental Association, have actively encouraged their membership to become TennCare providers. Children's access to both preventive care and treatment will be much improved.

The School-Based Dental Prevention Project, a collaboration between TennCare and the Department of Health, has enabled thousands of children to receive dental preventive services within the school setting in fiscal year 2001-2002. Prior to the enhancements, the school-based program served about half of the number of children as it has in the past year. Increased staff, newly developed staffing patterns and additional equipment have allowed the program to greatly expand preventive dental services to children. Following is a chart comparing the dental activities from last year to this year within the school-based program.

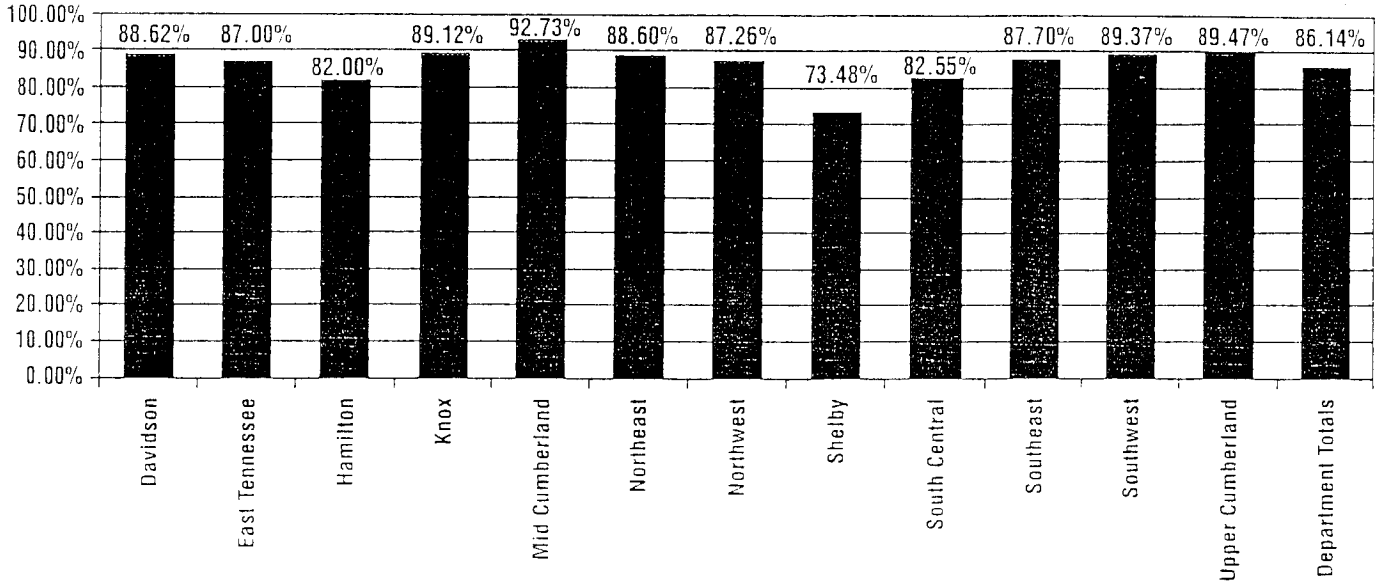
Mary McClean, RDH, "cleans" teeth and gums for health promotion and dental health education.

In order to more accurately measure, report, and evaluate the success of the school-based dental prevention project, the Bureau of Health Services developed a computer system using

Children's Oral Disease Prevention Services Data Comparison



Department of Children's Services Completion Rates of Dental Screens by Region as of September 15, 2002 (Cumulative)



% of children in custody with Dental Screens Completed within the Past 365 Days

software that allows entry of data from each school or community-based project directly onto a laptop computer while on location. This computer system was designed to collect data and report on preventive services delivered to groups of children and individually for TennCare recipients. Training of key dental staff from both the rural and metro regions was conducted on the new Dental Access Program in March 2002.

To further improve access for underserved children residing in rural counties lacking public health dental facilities, the Bureau of Health Services has purchased three high-tech mobile dental clinics for counties in the Mid-Cumberland, Northeast, and West Tennessee Regions. Two of the three mobile clinics are in operation, while the third is projected to be up and running by the end of 2002. There are also plans for outfitting mobile dental units with telemedicine equipment, which would allow for specialty consults with the University of Tennessee College of Dentistry.

Thus, with the expansion of the prevention program plus implementation of the dental carve-out, Tennessee's dental program is becoming a model for the nation. Significant improvements in public health dental services, and a much-improved TennCare network of dentists in private practice has made children's oral health in Tennessee something to smile about!

Jim Gillcrist, DDS, conducts a dental screen at a school-based site.

"Tennessee has taken the lead in implementing a 'Comprehensive Children's Oral Health Initiative' that serves as a model for the entire nation. This initiative is designed to improve the oral health of children because it includes both oral disease prevention and dental care. A strength is that this model requires the participation of the public and private sectors of dentistry"

Jim Gillcrist, DDS, MPH; TennCare Dental Director and Assistant Medical Director

Progress in Accessing EPSDT Services for Children in State Custody or at Risk of Custody

Centers of Excellence for Children in State Custody and at Risk of State Custody

The Children's Health Initiative, in coordination with TennCare and the for Children with Special Health Needs Steering Panel, has collaborated with five tertiary pediatric centers across the state to institute the Centers of Excellence (COEs). The five centers are located in the West, Middle, East, Northeast, and Southeast Regions (see map). Three COEs are currently in operation: Vanderbilt since January 2002; UT-Memphis Boling Center since February 2002; and East Tennessee State University since August 2002. Chattanooga (Southeast) and Knoxville (East) are expected to open by 2003. These Centers of Excellence serve children, identified primarily by the Department of Children's Services, who:

- Are TennCare enrollees;
- Are in state custody or at risk of custody;
- Have complex behavioral and/or medical needs;
- Have had difficulty finding access to adequate health and mental health services

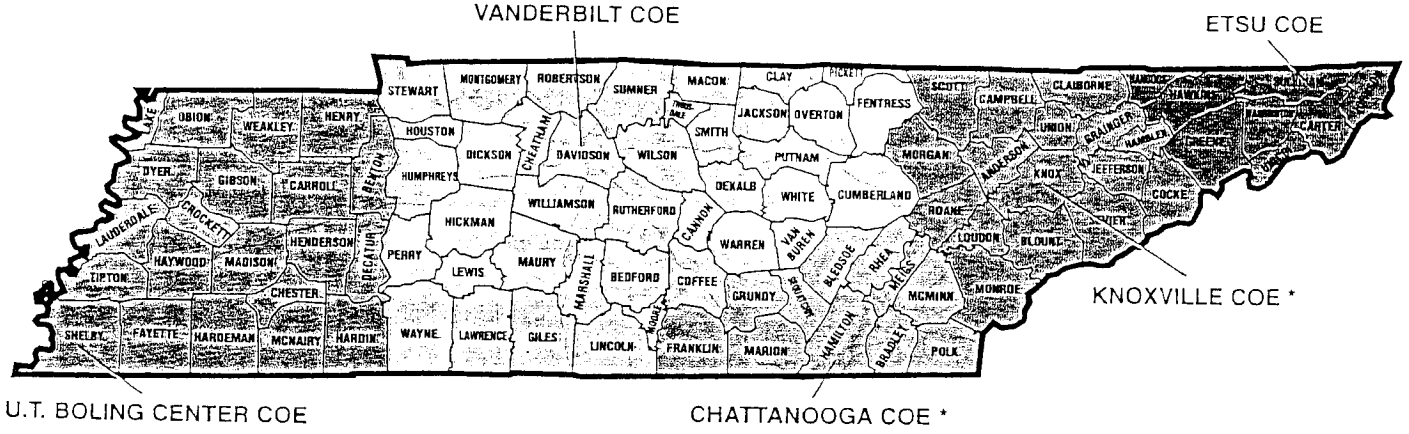
In addition to referrals from the Department of Children's Services, other referral sources include primary care providers, mental health professionals, juvenile justice staff, advocates, and caregivers.

"Andrew", age four, had disrupted two placements in the 8 months he'd been in DCS custody due to severe behavior problems, including aggression, self-biting, defiance, and toileting problems. Residential placement was being considered when he was referred to the COE for an evaluation. As a result of the evaluation, it was determined that, due in part to mental retardation, Andrew's current level of functioning was similar to a 2-year-old child. In a meeting with Andrew's case managers and his new foster mother, all were encouraged to understand and respond to Andrew's behaviors in the context of his developmental level. Andrew was referred for needed behavioral health and special education services. Andrew has remained in the current foster home.

UT-Boling Center of Excellence for Children in State Custody

The Centers provide expert services, primarily in the areas of comprehensive assessment and consultation, for children with complex needs who require sensitive coordination of care. The Centers provide the continuity and coordination of care through evaluation and subsequent consultation to the network of providers. In addition to serving individual children, the Centers also promote the development of the TennCare Pediatric Best Practice Network by both encouraging and supporting health profes-

Centers of Excellence



* Not operational, projected by 2003

Michael Cull, R.N., Vanderbilt University Center of Excellence for Children in State Custody

"Jamie" is a 16 year old girl who was provided inconsistent treatment in her community and had been suspected of having schizophrenia due to psychotic symptoms she experienced, along with unusual behaviors such as food hoarding that frightened her foster family. The COE team uncovered that her psychotic and food hoarding symptoms were possibly related to severe abuse and neglect in her past. Her DCS case worker had already connected the family with reactive attachment disorder parent training that enabled the foster family to begin to make necessary changes in their parenting approaches. The COE worked with the DCS case manager to develop a plan for consistent individual and family therapy for her post-traumatic and attachment issues, as well as psychiatric assessment and follow-up in the community.

ETSU Center of Excellence for Children in State Custody

sionals to become TennCare providers, as well as alerting the Bureau of TennCare to existing service system gaps.

Finally, the Centers are developing a close relationship with each of the Department of Children's Services Health Units in their designated regions. Centers of Excellence professionals travel to the Health Units monthly to facilitate case reviews and provide problem-solving recommendations. This "user friendly" model is building solid bridges between the provider community and the Department of Children's Services and Community Services Agency staff. Such collaborative efforts are certainly paying off, as demonstrated by positive responses from the caseworkers and

"Mathew," age 11, who has been in DCS custody for 8 years, was referred to the COE for a thorough assessment of his intellectual abilities prior to being placed in an adoptive setting. The assessment provided the potential adoptive mother with realistic expectations for Mathew's future, that in turn helped her with a decision to proceed with the adoption plan. Additionally, the COE team addressed and smoothed conflicting views among the "team" (e.g., DCS, the adoption agency, and the potential adoptive parent). Together, they addressed the child's issues of loss, transition, permanency, and visitation with birth siblings. The adoption was completed, there was improved cooperation among the representatives, the child is experiencing success, and he has regular visits with his siblings.

UT-Boling Center of Excellence for Children in State Custody

"Susie," a seven year old girl, was scheduled to appear before the judge who had removed custody from her natural mother, with uncertainty as to whether custody should be returned. There was also uncertainty as to whether her anxiety and behavioral disorder was a result of abuse by the natural family. The COE contributed a diagnostic evaluation for the child which confirmed the presence of ADHD and an anxiety disorder, but found sufficient strength in the natural family to return her to that environment. The COE psychiatrist adjusted her medication regimen to stabilize her and also worked with her in-home therapist, her DCS case manager, and most recently with the community mental health center to facilitate a successful transition home.

ETSU Center of Excellence for Children in State Custody

Overview of Services

- Case consultation and triage;
- Training and education to DCS staff and TennCare providers;
- Case coordination;
- Case review;
- Network development and monitoring;
- Psychiatric evaluations;
- Psychiatric medication management;
- Psychological evaluations;
- EPSDT screenings

providers in the field, the initial services data from the Centers, and most importantly from the children's own stories about their enhanced level of health and mental health and its effects on their well-being.

"Juan" is 16 year old deaf, mute, undocumented immigrant referred to the COE due to being ineligible for TennCare and at high risk for being removed into state's custody. Juan's father had recently died before acquiring a green card and Juan had come under state concern due to charges of domestic violence, as he had assaulted and injured his mother. Juan had recently been discharged from a psychiatric hospital with diagnoses of mood and conduct disorders and was being treated with medication, but had no follow-up psychiatric care. The Center's ability to fill this gap in service and provide psychiatric follow-up with continued medication adjustments has helped keep Juan stay out of custody. Juan has had no additional violent episodes and is excelling in public school.

Vanderbilt University Center of Excellence for Children in State Custody

"Mary," a 13 year old girl who was severely abused and developed post-traumatic stress disorder and dissociative identity disorder, was due to be discharged from a residential facility back to her foster home without treatment to address the severe trauma that elicited frequent and dangerous violent outbursts when in the more stressful "real world". Psychiatrists at the COE not only had previously accurately diagnosed her disorder, but later contributed to the negotiation of a community-based intensive treatment plan in an administrative court hearing of a TennCare appeal, working with her advocacy attorney and the DCS Health Unit. The plan will enable Mary to receive the appropriate treatment she needs in her community, but in a setting which will provide safety for her and her foster family.

ETSU Center of Excellence for Children in State Custody

Below is initial service data from April-June 2002, the first quarter when two of the COEs (Middle and West) were fully operational. As the COEs continue to develop, service numbers will increase significantly.

- 128 children were linked to services through triage calls;
- 79 children received psychiatric services;
- 109 children received psychological services;
- 19 children received pediatric services;
- 20 sets of professionals were formally trained in aspects of mental health issues

"This organized effort brought to the forefront the medical and behavioral health care challenges that children in state custody or at risk of custody frequently experience and assisted in the coordination of efforts among agencies to meet the needs of our children."

Commissioner
Page B. Walley, Ph.D.
Department of Children's Services

Progress in Accessing Behavioral Health Services for Children at Risk of State Custody

The Implementation Team

The Implementation Team, housed in the Department of Health, is comprised of a pediatrician, social worker, health advocate, executive secretary, and a mental health consultant from the Children's Health Initiative. This group has the responsibility to authorize behavioral health services for TennCare eligible children whose request for behavioral health treatment has been denied or delayed, putting them at risk of entering state custody.

The Implementation Team works to gather necessary information in order to negotiate the appropriate care with the Behavioral Health Organization, providers, family, and the Department of Children's Services. However, when unable to come to agreement, the Implementation Team has the authority to write a letter to a provider assuring payment for instituting the needed service.

To date, the Implementation Team has facilitated the services for 384 referred children, and has written 41 letters of authorization for 29 children to assure needed services not otherwise readily available. While these 29 children were well served through letters of authorization, the truly exciting statistic is that for the remaining 355 children, appropriate services were able to be secured by enhanced communication with the various stakeholders.

The Implementation Team began taking referrals in June 2000 and continues to the present. The Implementation Team has also been an active voice at the interagency meetings coordinated by the Children's Health Initiative to report on issues of care for children in the broader system. Their information, along with quarterly reports from the newly formed Centers of Excellence, is an invaluable source of data for the various child-serving agencies to work together to improve the system and services. Several systems gaps have been recognized and repaired through these meetings and collaborations, such as:

- A new process for children with mental retardation and behavioral health problems to access the Medicaid Waiver program for persons with mental retardation;
- A collaboration with the Department of Children's Services Child Protective Services Division to immediately gather pertinent family and social information on children referred to the Implementation Team in order to best determine their service needs;
- A creative collaboration with a statewide service provider to offer in-home wrap-around services to children who have multiple needs (e.g., both mental retardation and behavioral health service needs)

Fredia Wadley,M.D., Commissioner of Health, creator of the Implementation Team

"Our job is to push the envelope and the system. And for those times when the system does not meet the needs of the children and their families, our job is to bypass the system and immediately authorize the services children need in order to avoid state custody. The state later determines which of its departments will pay for the services, but the unusual thing about this process is that the child does not have to wait for the state to resolve payment issues in order to get services."

Fredia Wadley , M.D., Commissioner of Health

Implementation team members confer on a case. Pictured from left: Kacie Fitzpatrick, Larry Faust (director), Mary Jo Heimbigner, and Carla McCord

Twelve-year-old "Sarah" has a history of sexual abuse and longstanding problems with angry outbursts, including aggression towards others, destruction of property and multiple psychiatric hospitalizations. A Center of Excellence evaluation determined her diagnoses to include Post Traumatic Stress Disorder, Oppositional Defiant Disorder and a history of Major Depressive Disorder. The COE recommended residential behavioral health treatment. Sarah's outpatient therapist advised against placement in a standard residential treatment center due to the risk of victimization. An Implementation Team member negotiated authorization by the BHO for Individualized Residential Treatment (non-custodial therapeutic support home), thus avoiding commitment to DCS custody to access the most appropriate level of care to meet Sarah's needs.

Mary Jo Heimbigner, MSW, Implementation Team, Department of Health

"John" is a 17-year-old whose provider recommended residential treatment for behavioral problems. Although denied by the BHO on the basis of the clinical information provided, the court ordered that residential placement be provided or John would be placed in state custody. The Implementation Team (IT) was contacted. After gathering further information, the IT was concerned that John's behavior could be consistent with drug abuse. The IT was able to arrange a drug and alcohol evaluation that confirmed a drug abuse/addiction problem. Based on this additional information, the BHO approved a residential program for drug issues, thus avoiding custody.

Larry Faust, MD, Implementation Team, Department of Health

- A Commissioners' EPSDT Task Force workgroup to study the quality of discharge reports and recommendations from the Regional Mental Health Institutes (RMHI);
- A collaboration with the Regional Mental Health Institutes to implement the suggestions from the above EPSDT Task Force workgroup in addressing the quality of assessment information that impacts recommended discharge services from RMHI providers;
- Creation of a subcommittee reporting to the Commissioners' EPSDT Task Force with representatives from Department of Children's Services, Implementation Team, Department of Education, and Division of Mental Retardation Services to look into the issue of education of children in treatment placements outside their county of residence

There has been successful change in the percentage of children that entered custody in the two years of the Implementation Team operation as follows:

- 20% of referred "at-risk" children entered custody between June 2000 and June 2001;
- 12% of referred "at-risk" children entered custody between June 2001 and June 2002

The children who entered custody did so for child welfare and juvenile justice reasons rather than for lack of behavioral health services, reflecting the effectiveness of the Implementation Team in facilitating appropriate services for children at risk.

Carla McCord, executive secretary of the Implementation Team, receives a case referral.

Behavioral Health Initiatives

Psychological Evaluations

The Children's Health Initiative, in coordination with Advocare (TennCare's contracted Behavioral Health Organization), developed a task force to study the status of children's access to psychological evaluations. This task force, consisting of providers, state department representatives, advocates, and staff members of the Behavioral Health Organization (BHO), determined that several barriers to access did indeed exist. The task force made recommendations that would ultimately draw more providers into the scarce network of those willing to provide psychological evaluations. These recommendations included: 1) raising the rates for evaluations, 2) paying for indirect time such as the time to score, integrate the test results and write a report, and 3) educating providers about the option for one hour of testing that already exists without pre-authorization.

In addition to these changes, it was recommended that gatekeepers, such as caseworkers and court staff, be further educated about what levels of evaluation are needed in which circumstances, as well as how to best access evaluation services.

To date, the BHO has committed new money in this contract year to raise rates for evaluations and they have already begun to pay for providers' indirect time. Education efforts have been ongoing in the past year, including training regarding psychological evaluations at the annual juvenile judges conference and internal training of BHO care managers.

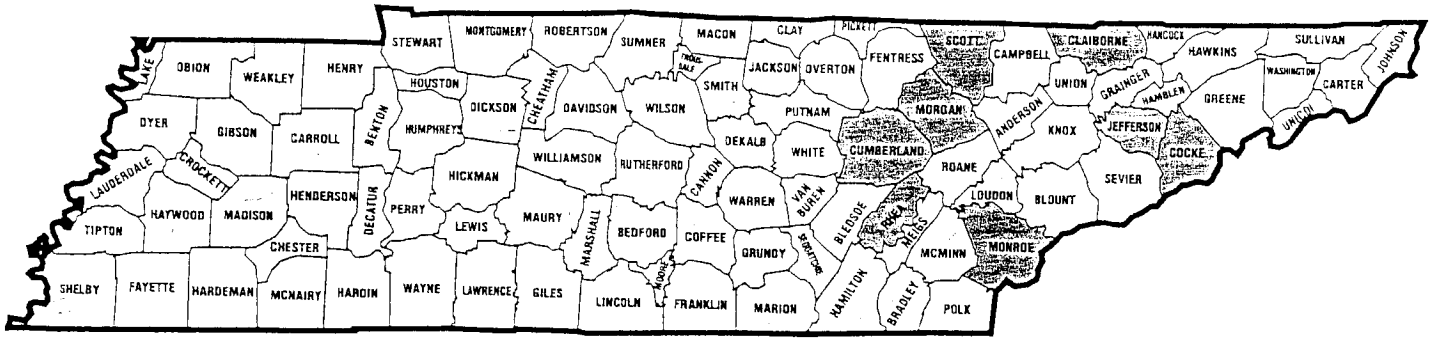
Rural Appalachia Project

The Rural Appalachia Project is an exciting collaborative venture to bring much needed behavioral health services to young TennCare enrollees in rural East Tennessee. The University of Tennessee Children's Mental Health Services Research Center, along with the Medical University of South Carolina Family Services Research Center, has developed a National Institute of Mental Health (NIMH) research proposal to examine the effectiveness of an intervention model using Multisystemic Therapy (MST). The intervention is designed to reduce the number of children adjudicated to state custody for serious behavior and related problems. MST has been deemed effective in major mental health reviews and endorsed by the U.S. Surgeon General's Office, the Office of Juvenile Justice and Delinquency Prevention, and NIMH as one of the most effective, economical and efficient interventions for these children and their families.

An advisory group, coordinated by the Tennessee Children's Health Initiative and including representatives from TennCare, Advocare, Youth Villages of Tennessee, and Tennessee Voices for Children, has worked closely with the research team to both develop the study and to maintain high ethical, practice and scientific standards.

The proposed five year Rural Appalachia Project will examine the effectiveness of MST in providing family-centered, home-based services to children involved with the court systems in eight rural, East Tennessee Counties. These counties have been characterized as having a paucity of mental health services, and it has been demonstrated that

Eight Tennessee Rural Counties Proposed for Intervention Research Project



children from rural Appalachian counties enter state custody at a higher rate than children from urban areas. The proposed project will reach 360 families with the MST intervention; outcomes with these families will be compared with outcomes of 360 families who will receive services as usual.

This proposal is in the last stages of review at NIMH and is likely to be funded within the 2002 calendar year. This venture represents the cutting edge of mental health services research and the results of the study should have national significance for improving services to rural children at risk of out-of-home placements.

> *"The Children's Health Initiative has been instrumental in coordinating the submission of a research grant proposal to the National Institute of Mental Health to study the efficacy of an intervention model (MultiSystemic Therapy) on reducing the number of children adjudicated to state custody. We appreciate the CHI's commitment to efforts aimed at reducing the number of children going into state custody."*
>
> Charlotte Bryson, Executive Director, Tennessee Voices for Children

Children with Mental Retardation (MR) and other Developmental Disabilities (DD)

Many children with MR/DD issues also have significant behavioral health needs. Their families often require support, such as in-home assistance, respite services, family counseling, and special behavioral skills training, in order to best parent their children.

To begin to address these needs, efforts at the state level have included:

- a comprehensive study, chaired by the Children's Health Initiative, and involving several State agencies to examine the needs and gaps in services for these children;
- a proposal for a full continuum of services for these children and a plan for developing expertise in the network;
- a commitment from TennCare to supply extra dollars for this population;
- a commitment from the BHO to work up a plan to serve these children

Presently, the BHO is working to devise a service plan to meet the needs of children with MR/DD and behavioral health problems. Meanwhile, some service providers in the state are stepping forward with resources to plug into this gap in the system of services. While the state is getting closer to having a system for the kinds of specialized services in place for these dually diagnosed children, other recent efforts have been started in the the meantime to address the short term needs. These include a push by the Division of Mental Retardation Services and the Disabilities Coordinator of TennCare to obtain a Medicaid exception to the federal moratorium on the MR waiver when children are in crisis (e.g., about to enter custody in order to get services for their difficult behaviors).

This exception has allowed the Implementation Team to write Letters of Authorization for these children to be placed in treatment options that are uniquely created for their special needs while they are in the process of getting longer term MR waiver services. For example, in working with Youth Villages, a provider for children's mental health needs across the state, the Implementation Team has worked out individualized service plans for dually diagnosed children that consist of such services as Professional Support Home (a family-based therapeutic setting with specially trained caregivers), behavioral specialists who work with the child on protocols for difficult behaviors, and therapists who work with the family of origin in order to help them prepare to receive the child back in the home. These children are now getting their unique needs met and making progress.

Finally, the Centers of Excellence for Children in State Custody have conducted in-service training events for providers on the topic of children with the dual diagnoses of mental retardation and behavioral health problems. Also, the Centers have been conducting excellent evaluation and follow-up consultation for children in state custody who are dually diagnosed and whose needs have been a challenge to meet appropriately.

A further step in the right direction for children with special needs is the Interdepartmental Autism Study Group. This group, chaired by the Children's Health Initiative, has been asked by the legislature to study the services in the state of Tennessee that directly aid children with autism, and to propose a plan for a comprehensive statewide integrated service model for children with autism. This group, with three focus groups (parents, providers, state interdepartmental leaders) began meeting in September 2002 and will submit a plan by December 2002 to a special legislative committee that will carry it forward to the General Assembly in 2003.

Other Priority Populations

Other plans that are in the works for children's mental health needs include special planning for priority populations within the TennCare enrollee group. TennCare, in discussion with the Children's Health Initiative and the BHO, has prioritized expansion money for children's services to be targeted to the following service areas:

- Crisis Stabilization Services, including specialty child/adolescent teams on mobile crisis units; crisis respite care; effective linkage to appropriate follow-up services;
- Alcohol and Drug Treatment network and service development;
- Sex Offender Treatment, including both residential and intensive outpatient models that would be coordinated with the juvenile justice system to ensure both community safety and mental health benefits;
- Services for MR/DD children with behavioral health problems;
- The addition of 20 new mental health professionals with child expertise to be added to the general TennCare network

All of the above needs have been researched throughout the state and have surfaced as the top priorities of need for our child/adolescent population. While there will always be challenges to meeting the many needs in the area of child behavioral health, the commitment of TennCare and the BHO to work hard in developing these important areas of service is a big step in the right direction.

"Based on 15 years of experience directing National Institutes of Health research with Tennessee's children, I believe the Children's Health Initiative is a huge step in the right direction. The CHI has facilitated important collaborative efforts between UT, state government, and private agencies. These collaborations hold great promise for developing new solutions to Tennessee's most pressing child-related problems. CHI is a model for encouraging public-private cooperation that the State could well replicate in other areas."

Dr. Charles Glisson, Director of Children's Mental Health Services Research Center, University of Tennessee School of Social Work

Charles Glisson, Ph.D., Director of Children's Mental Health Services Research Center, University of Tennessee School of Social Work

F. Joseph McLaughlin, Ph.D. Director, Children's Health Initiative

Working together we can continue to improve the lives of children. Nothing is more critical to the well-being of our communities and our state than the healthy development of all our children.

Two years of collaboration among parents, advocates, physicians, dentists, psychologists, nurses, social workers, community leaders, TennCare staff, and staff of child-serving departments of state government have resulted in many significant improvements in health care for children in Tennessee. It has been exciting and gratifying to work with such a large group of caring and competent people focused on the needs of children. Working together much has been achieved. And much remains to be done.

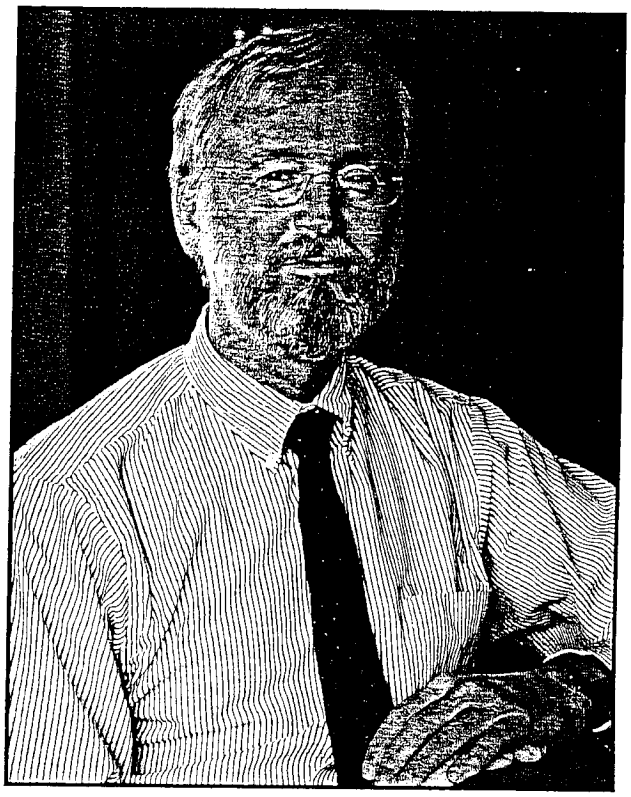
With the Health Department as a statewide provider of EPSDT, screenings have become much more available and accessible. Screening has also been improved through provider education and through the state's partnership with the Tennessee Chapter of the American Academy of Pediatrics. Screenings are the foundation of preventive health services and the gateway to treatment. The health and happiness of children depends on finding needs earlier and making connections between health care and behavioral health services that many children need desperately. Our next steps on screening should be:

- Development of more Medical Homes with accessible child health services from birth into adulthood;
- Use of developmental/behavioral screening tools to identify children who have developmental, emotional, and behavioral health needs;
- Integration of health and behavioral health services to meet the needs of the "whole child"

"Early results from the TennCare Select model are promising. The next step for Tennessee needs to be 'integrated whole child health care:' it is time to bring mental health and physical health together in a seamless fashion."

John Tighe
Deputy to the Governor for Health Policy

Michelle Vaughan, DDS, conducts an oral evaluation of a child in the school-based dental prevention project.



F. Joseph McLaughlin, Director of the Children's Health Initiative

Work is underway to improve behavioral health services. The Centers of Excellence bring expert services to children in state custody and those at risk of custody. Some of the state's finest child psychiatrists, child psychologists, and pediatricians are now involved in the care of these at-risk children. Also being improved are:

- Services for adolescents with drug and alcohol problems;
- Intervention and stabilization services for families and children in crisis;
- Treatment of children and adolescents with sexual behavior problems

Our array of behavioral health services must be expanded to provide a range of options for interventions in home, school, and community settings at levels of intensity that will meet the needs of children and families.

Children with mental retardation or developmental disabilities and behavioral health problems require our highest expertise, best planning, sustained commitment, and proper funding to provide home-based and community-based services that fit their needs. We will also need to further develop our Centers of Excellence to provide the clinical and educational resources to support primary care providers, mental health professionals, and staff of state agencies in providing specialized services for families and children with complex needs.

We have created a model children's oral health program in Tennessee. In the coming months we should see important growth of the TennCare dental network, including specialty dental care for children. Increased collaboration between the Health Department's preventive services together with the growing TennCare dental network will produce a comprehensive system of dental care for children enrolled in TennCare.

Tennessee has taken significant steps toward improving physical and mental health services for children. In the future, children's health must remain a priority. Working together we can improve the lives of Tennessee's children.

thanks for the care you give

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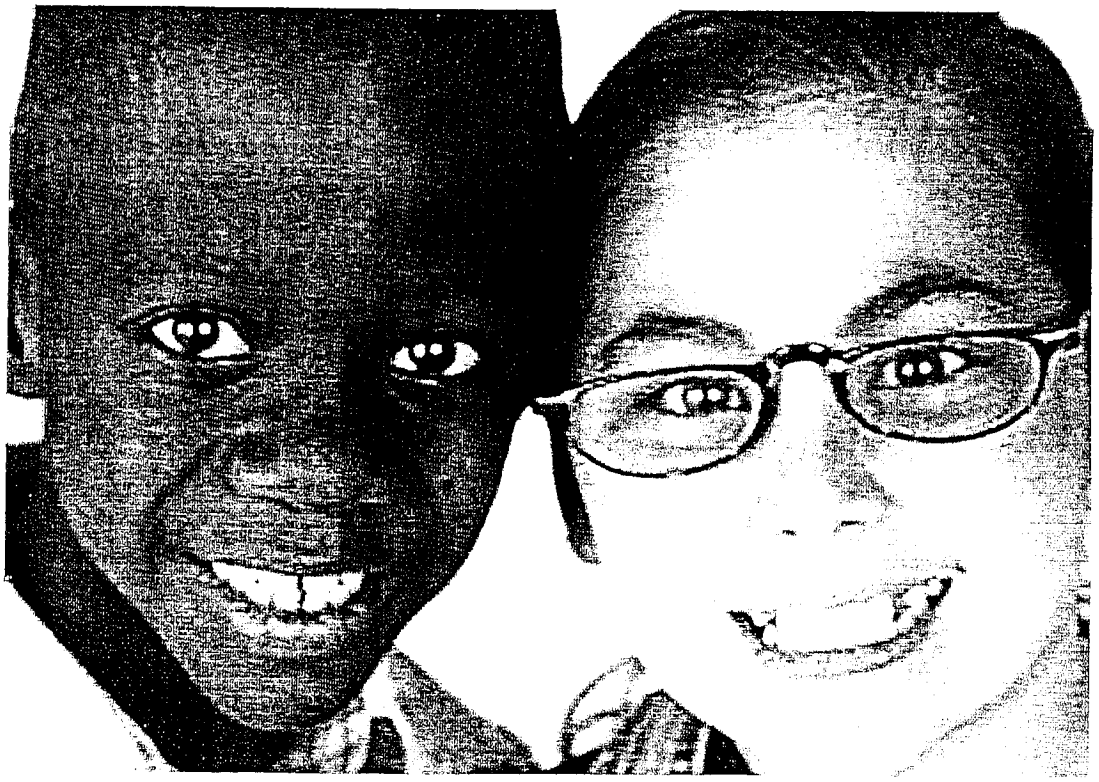
thanks for the care you give



Eye Exams

Hearing Checkups

Dental Checkups

Immunizations

Physical and Mental Checkups

Lab Tests

When they hurt you make it better and when they are sick, you are right there with them. But sometimes you worry about doing enough. That's why doctors and health departments offer **Caring for Kids,** a complete health system for kids up to 21 years of age who are served by TennCare. Tennessee **Caring for Kids** means complete health screenings for TennCare–covered babies, children, teens and young adults up to age 21. Call **1-800-669-1851** today and find out how you can give your kid the best care.

Para informacíon acerca de TennCare en español llame al 1-800-669-1851

Tennessee Caring for Kids

TENNCARE
A NEW DIRECTION IN HEALTH CARE

Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

John B. Progress Report
August 1, 2002 to January 31, 2003

TNAAP John B. Progress Report
August 1, 2002 to January 31, 2003

A new contract between the Bureau of TennCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) was executed for the period July 1, 2002 through June 30, 2003, and collaboration between TNAAP and the state continues.

The following provides an overview of activities under the contract between July 1, 2002 and January 31, 2003.

Representation on EPSDT cross-functional committees

TNAAP representatives meet with TennCare representatives monthly. TNAAP's EPSDT Director continues to participate in various committees and work groups such as the TennCare EPSDT Work Group (chaired by the TennCare Medical Director), the MCO Medical Director's meeting, and the TennCare and Children Work Group. In addition, Dr. Joel Bradley participates in the EPSDT Work Group and the MCO Medical Director's meetings, and Dr. Pat Davis has participated in the quarterly videoconferences sponsored by Tennessee Health Care Campaign.

Advice on issues related to coding, billing and documentation of EPSDT services

Dialogue between TNAAP and the State continues regarding appropriate coding and billing practices. In recent months, topics of conversation have included TB screening, newborn preventive health services and lab charges. There has also been both general and specific discussion regarding payment problems with individual MCOs. Discussions continue about appropriate documentation, most recently including providing feedback to the TennCare Quality Oversight Department about appropriate guidelines to be monitored with respect to hearing and vision screening.

TNAAP's EPSDT documentation forms were finalized and posted on TNAAP's web site in October. Updated versions of these forms were also forwarded to TennCare for posting on their web site and shared with the MCOs through the EPSDT work group. TNAAP distributed the forms at the TNAAP Open Forum and Pediatric Emergency Conferences held in Knoxville on September 13, and 14. Forms were also made available at TNAAP's Practice Manager Network training session on November 15, 2002. Further dissemination of the forms will occur as outlined in *Attachment I.*

Advice on the TennCare audit processes

The TennCare Oversight Department began scheduling audits in middle TN in early January. An audit was scheduled for January 23, 2003 with Columbia Pediatrics (the office of Pat Davis, MD, TNAAP's EPSDT Medical Director). State auditors cancelled the audit that morning due to snow and the audit is currently being rescheduled. An audit with another TNAAP member, Dr. James Hanley, MD, is scheduled for February

18, 2003. TNAAP staff and a member physician will be present during the audits and TNAAP will provide feedback about the audit process.

Development and implementation of training programs

TNAAP and the Office of the Children's Health Initiative established an educational advisory committee to oversee the educational activities of TNAAP and Cyber CE. This committee includes representation from TNAAP, two academic medical centers, The Tennessee Association of Family Physicians (TAFP) and a Pediatric Practice Manager. This committee had their initial meeting in November. The committee reviewed and provided feedback on draft educational materials prepared by TNAAP for distribution to physician offices by TNAAP's Coding Educator. Cyber CE presented an on-line presentation of Cyber CE's proposed EPSDT web site.

TNAAP is currently revising our educational materials to incorporate the feedback from this meeting. TNAAP has also developed an alternate web site model, which we feel may be informative and user-friendly. *See Attachment II* for a sample of the educational materials and TNAAP's web site draft. TNAAP's EPSDT Director met with staff of Cyber CE in December and shared TNAAP's web site recommendations.

Dr. Joel Bradley provided a coding training session for the EPSDT Work Group on January 13, 2003.

TNAAP hired a coding educator, Jacque Clouse, RHIT, CCP, who will begin work with TNAAP February 3, 2003. TNAAP did not fill the position for the original targeted effective date of October 1, 2002. Obstacles to filling the position included candidate's concerns about one of three factors. Those factors included concerns about the amount of travel, the pay rate, and the fact that the position is funded through a state contract (often perceived as not very stable particularly in a time of changing administrations). Fortunately, two very qualified candidates were identified and interviewed in December and January and a selection was made. For details about TNAAP's recruiting efforts see *Attachment III.*

TNAAP is continuing to disseminate the EPSDT video and other educational materials previously developed. The EPSDT Director has begun making physician office visits to distribute information about EPSDT and introduce the concept of the Coding Educator. The EPSDT Director has also established dialogue with Vanderbilt University Medical Center's Pediatric Residency Program and UT Knoxville's Family Practice Residency Program regarding working together on improving EPSDT residency training programs.

EPSDT newsletter articles appeared in the winter edition of the TNAAP newsletter. These topics include:

- EPSDT forms posted on web site
- A table obtained from TennCare that compares the benefit package for TennCare through 12/31/02 to the new TennCare Medicaid and TennCare Standard benefit packages effective January 1, 2003.

- An article prepared in cooperation with DCS regarding problems in obtaining EPSDT screens for Children in State custody
- An article regarding the EPSDT chart documentation forms, why practices should use them and where to obtain the most current versions of the forms.

See *Attachment IV* for sample newsletters (the Spring newsletter included numerous EPSDT related articles as well and a copy of this issue is also included).

Serve as a liaison with other professional organizations

TNAAP has continued dialogue with the TAFP regarding EPSDT services. An EPSDT newsletter article was forwarded for their information and use in their newsletter upon their discretion. TNAAP worked with TAFP to get a Family Practice representative on the Educational Advisory Committee and one of their Board members (Alan Wallstedt, MD) was named to that committee. Dr. David Kalwinsky, MD, TNAAP Vice President, participated in a TAFP Board meeting on October 31, 2002.

Establish a point person to work with TDH

TNAAP's EPSDT Director continued to work with the state's MCH Consultant for the Bureau of Health Services (Annette Goodrum) to work together on resolution of issues related to EPSDT screening between pediatricians and health departments.

Assist TennCare in Identifying Barriers to Delivery of EPSDT Services

A significant portion of the discussion at monthly meetings includes dialogue about barriers to the delivery of care for children. Problems recruiting and retaining pediatricians and other primary care physicians are primarily attributed to poor reimbursement and "hassle factors". One of the significant hassle factors relates to the multiple drug formularies used by the TennCare MCOs. TNAAP has had lengthy dialogue with various TennCare representatives about the need for a common pediatric formulary. For more information on TNAAP efforts and suggestions on this topic please refer to *Attachment V*.

TNAAP has also provided much input about problems with reimbursement and other "hassles". More detail is available upon request.

Assist with implementation of Screening Guidelines

There has been much discussion in our dialogue regarding the new developmental and behavioral screening guidelines scheduled for implementation some time in 2003. A TNAAP member piloted the forms in her office and provided specific feedback. Multiple TNAAP members have expressed deep concern about the practicality of implementing these new tools in the current environment. It is the opinion of TNAAP leaders that the additional cost and time required to utilize the tools will not be well received in the provider community if reimbursement is not adjusted. In addition, pediatricians are concerned about the lack of participating behavioral providers to treat children who may be identified. TennCare and TNAAP representatives have agreed to work together on

pilots in practices in each of the grand regions during the first half of 2003. There is also ongoing discussion regarding reconvening the screening guidelines committee to discuss this issue.

Collaborative efforts between the State and TNAAP continue to improve access to EPSDT services and appropriate documentation of those services.

Attachment I
Distribution of EPSDT Forms

TNAAP EPSDT Forms

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) has developed EPSDT documentation forms for use in physician offices. These forms were developed with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division. Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

The forms will be distributed to providers as follows:

	Action	Status
1	TNAAP will mail members a copy of the forms and notify them they will also be posted on the web site.	*
2	TNAAP will distribute the forms to the MCOs and will encourage their use of the forms.	Complete
3	The forms will be posted on the TNAAP web site.	Complete
4	The forms will be posted on the TennCare web site.	Complete
5	TNAAP will do a newsletter article about the forms and explain that they are posted on the web site.	Complete
6	TNAAP will contact TAFP and ask them to run the article or a similar announcement.	*
7	TNAAP will contact TMA and ask them to run the article or a similar announcement.	*
8	TNAAP will promote and distribute the forms through office visits, professional meetings and educational programs.	Currently being distributed
9	TNAAP will ask CYBER CE to promote the forms in their on-line sessions and any other educational initiatives they may be involved in.	*
10	The TennCare Quality Oversight Dept. will promote and distribute copies of the forms throughout the audit process.	Currently being distributed

These actions were on hold pending a final decision by the CHI Committee about adding the TNAAP logo to the form. The decision was made to add the logo at the November CHI Meeting. Once logo has been incorporated, further distribution will begin.

01/23/03

Attachment II
Draft Educational Materials and Web Site

Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

EPSDT Overview – DRAFT

December 2002

DRAFT

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Nashville, TN 37215-9201
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Ruth E. Allen
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Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

EPSDT Overview – DRAFT

DRAFT

Table of Contents

Rev. 11/05/02rea

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EPSDT – What is it?
And Why You Should Care

Per Educational Advisory Committee
Insert page here describing current situation in TN

Include:

- Medicaid requirements
- TN current and target screening rates
- Some sort of explanation of John B. vs. Menke lawsuit and EPSDT compliance rates that were agreed to.

DRAFT

Definition of EPSDT

E Early

P Periodic

S Screening

D Diagnosis

T Treatment

Early – Assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic – Assessing a child's health at key points in his/her life to assure continued healthy development;

Screening – Using tests and procedures to determine if children being examined have conditions requiring closer medical/mental health or dental attention;

Diagnosis – Determining the nature and cause of conditions identified by screenings and those that require further attention; and

Treatment - Providing services needed to control, correct, or reduce physical and mental problems.

Rev. 11/05/02rea

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Reimbursement for EPSDT Services

TennCare reimbursement for well child screens may be better than you expect. TennCare pays for services often not compensated for under private insurance. In most cases TennCare MCOs pay separately for each of the services listed below.

EPSDT Screening Services

Service
Evaluation and management code
Hearing Screen
Vision Screen
Vaccine Administration fee
Hemoglobin Test
Urine Test
Developmental/Behavioral Screen

Rev. 12/06/02 rea

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Insert EPSDT Frequency Table here

TNAAP
Components of EPSDT Exam
History and Physical

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Initial and Interval History - The comprehensive health history must be obtained from an interview with the parent/guardian or through a form or checklist completed by the parent/guardian. The history must contain, but not limited to, the following: • Present health status and past health history of recipient • Developmental information • Allergies and immunization history • Family history • Dietary history • Age appropriate social history • Current medication(s). **Documentation** - Once the health history is recorded in the medical record, only an update is required for subsequent visits.	**Developmental/Behavioral History** - Age-specific developmental milestones must be assessed at each preventive visit. Developmental/behavioral screening is an ongoing process that is most effectively performed using standardized validated screening tools. The tools recommended for use by the TennCare Screening Guidelines Committee can be located on the State's Web-site at http://www.state.tn.us/tenncare/CaringforKidsdev.html. If findings appear abnormal, the child should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment. **Documentation**- Results of the developmental/behavioral screenings must be documented in the medical record with a copy of the questionnaire and checklist included. Results and referrals must also be documented in the medical record.
Physical Exam -The physical examination must be performed with the child unclothed, but appropriately draped. This process can reveal obvious physical defects including nutritional abnormalities, orthopedic disorders, hernia, skin disease and/or genital abnormalities. The measurements in the column to the right are required. **Documentation** -Measurements in numerical values are to be recorded in the medical record at every visit. The head circumference, height, and weight should also be plotted on an age-appropriate growth chart available from the Centers for Disease Control website at www.cdc.gov/nchs.	Head circumference Head Circumference should be measured with a tape measure at each visit during the first two (2) years of life. Height Height should be measured at each visit. The height for infants up to two (2) years should be measured as recumbent length using a properly constructed measuring device. Height measurements for children over two (2) years of age should be accomplished using vertical measuring board or fixed wall device. Weight Weight should be measured at each visit with the child nude or wearing an examination gown. Blood Pressure (B/P) B/P measurement should begin at the age of three (3) years unless there is a clinical indication to begin prior to that time. The B/P should be measured at each screening visit using an appropriately sized cuff.

TNAAP
Components of EPSDT Exam
Hearing and Vision Screening

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Recommendations of the TennCare Caring for Kids Screening Guidelines Committee (1999):

HEARING SCREENING:

- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Newborn hearing screening is recommended for all newborn infants. As of January 1999, not all hospitals in the State have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003.
- Recommended testing intervals: The committee recommends an objective hearing screening test once in each of the following age ranges: 3-6, 10-13, 14-18. Screening should be conducted at the first visit during the above listed intervals at which the patient is cooperative.
- Acceptable methods of objective hearing screening include: conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

VISION SCREENING

- Recommended testing intervals:
    - The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. The procedures

should be conducted at the first visit during which the patient is cooperative.
    - The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18.
- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Sterotest at 40 cm (630 secs of arc).
- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling F, HOTV, Picture Tests, Allen Figures, LH Tests.
- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

For additional information on requirements of subjective and objective tests by age, please refer to the guidelines on the provider page of the TennCare web site at http://www.state.tn.us/tenncare/CaringforKidsguidelines.html

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TNAAP
Components of EPSDT Exam
Laboratory

Requirement

The following lab procedures or screenings should be conducted in accordance with the American Academy of Pediatrics' (AAP) Recommendations for Preventive Pediatric Health Care:

• *Hereditary/Metabolic Screening* • *Hematocrit/Hemoglobin* • *Urinalysis* • *Lead Screening and Testing*	• *Tuberculosis Screening and Testing* • *Cholesterol Screening* • *STDs* • *Pelvic Exam*

Documentation

The results of all laboratory tests must be documented in the medical record.

References/Resources

http://www.aap.org/policy/re9939.html

Hereditary/Metabolic Screening

Requirement

Tennessee State Law requires every newborn to be tested for metabolic/genetic defects that would result in mental retardation or physical dysfunction if not treated in a timely manner. The following tests are required:

• Phenylketonuria (PKU) • Hypothyroidism • Hemoglobinopathies	• Galactosemia • Congenital Adrenal Hyperplasia (CAH).

Documentation

Screening visits between birth and two months should be documented in the medical record by the provider, including the tests done and results received.

References/Resources

1. AAP Policy Statement on Newborn Screening (RE9632) - http://www.aap.org/policy/01565.html
2. Maternal and Child Health, Tennessee Department of Health's Newborn Screening Program - http://170.142.76.180/Mch/genetics.htm.

Hematocrit/Hemoglobin

Requirement

To reduce risk of developmental delays and behavioral disturbances associated with iron deficiencies, hematocrit and/or hemoglobin should be tested on:

• Children 9 months of age, • Adolescents 14 years of age,	• All menstruating adolescents, annually, and • Pregnant adolescents.

Documentation

Test results, as well as any further evaluation, treatment, counseling or referral must be documented in the medical record.

References/Resources

http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00051880.htm

Urinalysis

Requirement

Most infection-related renal damage occurs during infancy and early childhood. Timely identification of infection, appropriate treatment, detection of patients at risk for renal scarring, and prevention of recurrent infection can greatly reduce the risk of adverse outcomes.

A minimum of one (1) dip stick urinalysis for leukocytes must be performed:

• At 5 years of age, • At 16 years of age, and	• Annually for all sexually active male and female adolescents.

Documentation

Test results, as well as appropriate treatment and referral, if indicated, must be recorded in the medical record.

References/Resources

http://www.aap.org/policy/RE9939.html

Lead Screening and Testing

Requirement

Children enrolled in Medicaid have a greater chance of having elevated blood lead levels than other children have. Blood lead levels (BLLs) as low as 10 mcg/dL have been associated with harmful effects on children's learning and behavior. Very high BLL (□70 mcg/dL) can cause devastating health consequences, including seizures, coma and death.

Health Care Financing Administration (HCFA), now called Centers for Medicare and Medicaid Services (CMS), recommends administration of a blood lead screening test for all children enrolled in Medicaid at ages 12 and 24 months; children who have not previously been screened should be tested at ages 36--72 months. Administrating a risk-assessment questionnaire instead of a blood lead test does not meet Medicaid requirements.

Once the initial BLL is performed, further testing may be required. If the results are:

• 10-19 mcg/dL, perform confirmatory venous BLL within 1 month. • 20-44 mcg/dL, perform a confirmatory venous BLL within 1 week. • 45-59 mcg/dL, perform a confirmatory venous BLL within 48 hours.	• 60-69 mcg/dL, perform a confirmatory venous BLL with 24 hours. • >69 mcg/dL (urgent condition requiring hospitalization), perform immediately as an emergency lab test.

Documentation

The medical record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should also be documented in the medical record.

References/Resources

http://www.aap.org/policy/re9815.html.
http://www.state.tn.us/health/lead/professionals.htm
http://www.phppo.cdc.gov/cdcrecommends/showarticle.asp?a_artid=P0000975&TopNum=50&CallPg=Adv
http://www.state.tn.us/tenncare/pdf/tsop36-3.pdf

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TNAAP
Components of EPSDT Exam
Immunizations

Requirement

By ensuring that children are immunized on time, we can provide the best available defense against many dangerous childhood diseases. Immunizations protect children against: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), haemophilus influenza type b, chickenpox, pneumococcal and others.

Immunizations, if needed, should be given at the time of the EPSDT screening exam or at any other contact with the child. See the *Recommended Childhood Immunization Schedule* approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) regarding recommended ages for routine administration of currently licensed childhood vaccines.

Documentation

All immunizations must be documented in the medical record indicating type, lot number, date and signature, as well as any adverse reactions. If immunizations have been given at another facility, a copy of that record should be retrieved for the current record.

Billing

Immunizations given to adolescents 19 and 20 years of age should be billed using the appropriate CPT administration and serum codes. Immunizations given to children and adolescents aged 0-18 years fall under the Vaccines for Children (VFC) billing guidelines.

You are eligible to receive free vaccine serums from the Tennessee Dpeartment of Health's VFC Program. To enroll, contact the Tennessee Department of Health at 615-532-8513.

References/Resources

http://www.cdc.gov/nip
http://www.cdc.gov/nip/recs/child-schedule.htm#Printable
http://www.immunize.org/catg.d/p4060scr.pdf
http://www.immunize.org/catg.d/p2022b.pdf

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TNAAP
Components of EPSDT Exam
Health Education/Anticapatory Guidance

Requirement

Anticipatory guidance and health education are an integral part of the screening and must be provided by the health care professional. Age appropriate topics/information must be presented during each screening. The AAP recommends, at a minimum, that the following topics be addressed at each visit:

1. Injury Prevention
2. Violence Prevention
3. Sleep Positioning Counseling
4. Nutrition Counseling

Providers should use oral or written information.

Documentation

Specific topics addressed must be documented in the medical record. If age appropriate documentation forms are used, simply checking the items that apply is all that is necessary; however, any and all documentation should be dated and signed appropriately.

References/Resources

http://www.brightfutures.org/anticipatory/index.html
http://www.aap.org/family/tippmain.htm
http://www.aap.org/policy/re9832.html
http://www.aap.org/policy/re9946.html
http://www.brightfutures.org/nutrition/index.html

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TNAAP
Components of EPSDT Exam
Dental Referrals

This page is currently under revision

DRAFT

TNAAP
KEY EPSDT Codes

Preventive Medicine Codes
99381 New patient, under 1 year of age
99382 New patient, 1 – 4 years of age
99383 New patient, 5 – 11 years of age
99384 New patient, 12 – 17 years of age
99385 New patient, 18 – 21 years of age
99391 Established patient, under 1 year of age
99392 Established patient, 1 – 4 years of age
99393 Established patient, 5 – 11 years of age
99394 Established patient, 12 – 17 years of age
99395 Established patient, 18 – 21 years of age

Newborn Care

99431 History and physical exam
99432 Normal newborn care
99435 History and physical exam (assessed and discharged same day)

Developmental Testing
96110 Limited developmental testing and screening
96111 Extensive developmental testing

Laboratory Tests
85018 Hemoglobin
85013 Hematocrit
83655 Blood lead test
82465 Cholesterol
36406 Venipuncture, under 3 years of age
36410 Venipuncture, over 3 years of age requiring MD
36415 Routine venipuncture, including finger or heel stick
81000 Dipstick UA with microscopy
81001 Automated UA with microscopy
81002 Dipstick UA without microscopy
81003 Automated UA without microscopy

Hearing Screening

92506 Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92551 Screening test, pure tone, air only
92552 Pure tone audiometry, threshold, air only
92553 Pure tone audiometry, threshold, air and bone

Vision Screening
99172 Automated or semi-automated, quantitative exam, e.g. Snellen on a machine
99173 Quantitative visual acuity exam, e.g. Snellen chart on the wall

CPT Modifiers
-25 Significant separately indentifiable evaluation and management service by same physician on same day of procedure of other service
-90 Reference lab performed procedure, e.g. sending out a blood lead test
-91 Repeat lab test on same visit, e.g. confirmatory hemoglobin

ICD-9 Codes (Diagnosis)
V20.2 Routine infant or well child check
Newborn care
Premature infant

Immunizations (see back)

Immunizations 90471 Vaccine administration code, one injection 90472 Vaccine administration code, more than one injection, code for each subsequent injection (requires 90471 code) 90633 Hepatitis A, child or adolescent, 2 dose 90634 Hepatitis A, child or adolescent, 3 dose 90645 HIB, HbOC conjugate, 4 dose 90646 HIB, PRP-D conjugate, booster only 90647 HIB, PRP-OMP conjugate, 3 dose 90648 HIB, PRP-T conjugate, 4 dose 90669 Pneumococcal vaccine, polyvalent, under 5 years of age 90700 DTaP 90701 DTP 90707 MMR 90712 Oral Polio Vaccine (OPV) 90713 Intramuscular Polio Vaccine (IPV) 90716 Varicella vaccine 90718 Tetanus and diphtheria (Td), over 7 years of age 90720 DTP-Hib 90721 DTaP-Hib 90723 DTaP-Hepatitis B-IPV 90733 Meningococcal vaccine 90744 Hepatitis B, child or adolescent, 3 dose schedule	

BUREAU OF TENNCARE
DIVISION OF QUALITY OVERSIGHT
EPSDT AUDIT TOOL – 0-20 YEARS OLD

Name_____ ID#_____

Age_____ D.O.B. _____ MCO _____

Provider_____ DOS_____

Reviewer:

I. HISTORY	YES ☐	NO ☐	
Past	YES ☐	NO ☐	
Family	YES ☐	NO ☐	
Interval	YES ☐	NO ☐	NA ☐
Developmental /Behavioral Assessment	YES ☐	NO ☐	
Nutritional Assessment	YES ☐	NO ☐	
Lead Risk Assessment (6 mos. thru 72 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Risk Assessment (Begins at 2 years)	YES ☐	NO ☐	NA ☐

II. COMPREHENSIVE UNCLOTHED PHYSICAL	YES ☐	NO ☐	
Exam	YES ☐	NO ☐	
Weight	YES ☐	NO ☐	
Height	YES ☐	NO ☐	
Blood Pressure (Begins @ 3 yrs.)	YES ☐	NO ☐	NA ☐
Head Circumference (thru 24 mos.)	YES ☐	NO ☐	NA ☐
Pelvic Exam (If indicated)	YES ☐	NO ☐	NA ☐
Developmental Screening/Assessment	YES ☐	NO ☐	

III. LABORATORY TEST	YES ☐	NO ☐	
Newborn Panel	YES ☐	NO ☐	NA ☐
Hemoglobin or Hematocrit (9 mos. & 11-20 yrs.)	YES ☐	NO ☐	NA ☐
Urinalysis (5 yrs. & 11 - 20 yrs.)	YES ☐	NO ☐	NA ☐
Lead Screen (12 mos. & 24 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Test (If Indicated)	YES ☐	NO ☐	NA ☐
TB Test (If Indicated)	YES ☐	NO ☐	NA ☐
STD Screening (If Indicated)	YES ☐	NO ☐	NA ☐
Lead Screen Due to High Risk Assessment	YES ☐	NO ☐	NA ☐

IV. HEALTH EDUCATION	YES ☐	NO ☐

V. VISION	YES ☐	NO ☐

VI. HEARING	YES ☐	NO ☐

VII. DENTAL REFERRAL	YES ☐	NO ☐	NA ☐

EPSDT AUDIT TOOL 0-20 YEARS

IMMUNIZATIONS Up To Date	YES ☐	NO ☐			
	YES	NO	NA	CONTRAINDICATION	COMMENTS, REASONS IMMUNIZATIONS NOT GIVEN
Hepatitis B					
Diphtheria, Tetanus, Pertussis					
H. Influenza Type B					
Polio					
Measles, Mumps, Rubella					
Varicella Zoster					
Hepatitis A					

REFERRALS			
Miscellaneous ☐	*ENT* ☐	*PT, OT, Speech, Hearing* ☐	*Orthopedist* ☐
Ophthalmologist ☐	*Cardiopulmonary* ☐	*Allergist* ☐	*Surgeon/Plastic Surgeon* ☐
Urologist/Nephrologist ☐	*Dermatologist* ☐	*Neurologist* ☐	*Gastrologist* ☐
Endocrinologist ☐	*Mental Health* ☐	*None* ☐	*OB/GYN* ☐
Tennessee Early Intervention System ☐	*School System* ☐		

I. HISTORY

I. HISTORY - INITIAL AND INTERVAL HISTORY

This comprehensive history may be obtained from interview of the parent or guardian or through a form or checklist completed by the parent or guardian. History must contain, but is not limited to:

- Present health status and past health history or recipient
- Developmental information
- Allergies
- Family history
- Dietary history
- Age appropriate social history
- Current medication(s)

Once the health history is recorded in the medical record, only an update is required for subsequent visits.

DEVELOPMENTAL/BEHAVIORAL SCREENING

Age specific developmental "milestones' must be assessed at each preventive visit.

If findings appear abnormal, these children should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment.

Results of developmental/behavioral screening must be documented in the medical record. (See Section: Developmental/Behavioral Survey Tools)

NUTRITIONAL ASSESSMENT

Refer to age appropriate standardized screening forms.

CHOLESTEROL SCREENING

Cholesterol Risk Assessments. (beginning at age two (2)) Should include information which identifies parent or grandparent with coronary or peripheral vascular disease below age 55, parent with elevated blood cholesterol, or child with risk factors for future coronary disease (physical inactivity, obesity, diabetes mellitus). (Refer to age appropriate standardized screening forms and periodicity schedule.)

LEAD SCREENING

Document if a lead risk assessment was completed. Assessment begins at 6 months and then occurs at every encounter afterwards through 12 months. As soon as a child is determined to be at high risk for lead, testing must be completed. If a child is at low risk, then testing must be done at 12 months of age and again at 24 months. Lead assessment and testing would be found in physician's notes, immunization record, or lab reports.

The medical record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should be documented in the medical record. Refer to age appropriate standardized screening form section and Lead Screening Assessment.

II. COMPREHENSIVE UNCLOTHED PHYSICAL

The physical examination must be performed with the child unclothed but suitably draped. A comprehensive physical examination must be completed, including an examination of the heart with a stethoscope. Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including nutritional abnormalities, orthopedic disorders, hernia, skin disease, and genital abnormalities.
The following measurements are very important during the developmental years and should be recorded and compared to those considered normal for the same age.

MEASUREMENTS

The **Head** circumference should be measured with a tape measure at each visit during the first two years of life.

The **Height** should be measured with each visit.

The **Weight** should be measured at all ages. This may be found on growth charts or in physician documentation.

BLOOD PRESSURE (B/P) MONITORING

Should being at the age of three (3) years unless there is a clinical indication to being prior to that time. The B/P should be measured at each screening visit using an appropriate sized cuff.

PELVIC EXAMINATION

All sexually active adolescents or any female 18 or older should be screened annually for cervical cancer by use of a Pap test. Adolescents with a positive Pap test should be referred for further diagnostic assessment and management. (Refer to age appropriate standardized screening forms and STD/Pelvic Section)

Document findings on pelvic examination as well as Pap results must be documented in the medical record. Referral(s), if indicated, must be documented as well.

Document whether the PE was complete. To be complete it must include an unclothed assessment of all of the following: skin/nodes, head, neck, eyes, ears, nose, throat/mouth, heart, lungs, abdomen, genitalia, extremities/hips, spine and neurological functioning. Look for this information in well-child visit documentation.

III. LABORATORY TEST

NEWBORN METABOLIC SCREENING

The Tennessee State law requires that every newborn be tested for metabolic/genetic defects that would result in mental retardation or physical dysfunction if not treated in a timely manner. The following tests are required:

- Phenylketonuria
- Hypothyroidism
- Hemoglobinopathies
- Galactosemia

These tests are generally done while the infant is still in the hospital nursery. However, there may be instances when this is not done (ex. Infants born at home). The PCP must ensure that these tests have been done in a timely manner. If discrepancies are found, the provider should notify the local Health Department.

On screening visits between birth and two months, the provider should document that testing has been completed, as well as test results. (Refer to age appropriate Standardized Screening Form and Lab section).

HEMATOCRIT OR HEMOGLOBIN (Hct./Hgb.)

Hgb. And 11ci. Screening should be done at or by ages 9 months and 15 years. Annual Hct. Or High screen should be done on females presenting with the following:

- Moderate to heavy menses
- Chronic weight loss
- Nutritional deficit
- Athletic activity

Document if a hemoglobin/hematocrit was obtained. It may be noted as PCV, and it may be found in physician documentation or in a lab report. (Refer to age appropriate standardized screening form and lab section)

URINE TESTING

Most infection-related renal damage occurs during infancy and early childhood. Timely identification of infection, appropriate treatment, detection of patients at risk for renal scarring, and prevention of recurrent infection can greatly reduce the risk of an adverse outcome.

A minimum of one (1) dip stick urine must be performed at five (5) years of age.

Documentation of test results, as well as appropriate treatment and referral, if indicated, must be recorded in the medical record. (Refer to age appropriate standardized form and lab section)

TUBERCULIN TEST

TB test may be found on immunization sheet.

The TB Risk Assessment Questionnaire should be completed beginning at age 12 months and at each screening thereafter, in order to determine risk. For high-risk groups, the Committee on Infectious Disease recommends TB skin testing immediately and every 1-3 years.

TB skin test should be read and documented by a health professional. The Health Department must be notified of any high-risk child or any positive skin test reading.

Documentation:

The administration of the tuberculin skin test and the results must be recorded in the medical record with appropriate dates and signatures. Treatment and/or referral must also be documented in the medical record.

(Refer to age appropriate standardized screening form and assessment section)

CHOLESTEROL TESTING

Optional cholesterol testing by practicing physicians may be appropriate for children who are judged to be at higher risk for coronary heart disease independent of family history. For example, adolescents who smoke, consume excessive amount of saturated fats and cholesterol, or are overweight may also be tested at the discretion of their PCP. For parents who do not know their cholesterol levels, PCPs should strongly encourage them to have their levels measured. (Refer to age appropriate standardized screening form and assessment section)

LEAD TESTING

Children enrolled in Medicaid have a greater chance of having elevated blood lead levels than other children. Blood lead levels (BLLs) as low as 10 mcg/dL are associated with harmful effects on children's learning and behavior. Very high BLL ($\geq$70 mcg/dL) can cause devastating health consequences, including seizure, coma, and death.

Health Care Financing Administration (HCFA) policy calls for children enrolled in Medicaid (TennCare) to have their BLL measured at 12 and 24 months of age, while children are 36-72 months should be tested if they were missed earlier. (*State Medicaid Manual*, September 1998. Paragraph 513.2).

In children with screening BLL.10 mcg/dL, the first step is to perform a confirmatory venous BLL. This should be performed immediately if screening BLL>70 mcg/dL (urgent condition requiring hospitalization); within 48 hours if screening result is 45-69 mcg/dL; within 1 week if screening result is 20-44 mcg/dL; within 1 month if screening result is 10-19 mcg/dL.

Documentation:

The medication record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should be documented in the medical record. (Refer to age appropriate standardized screening form and assessment section)

SEXUALLY TRANSMITTED DISEASES (STDS)

Adolescence is a time of experimentation and risk taking. Developmentally, adolescents are at a crossroads of health. Emerging cognitive abilities and social experiences lead adolescents to question adult values and experiment with health risk behaviors. Some behaviors threaten current health, while others may have long-term health consequences.

All adolescents should be asked about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection. They should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDs , including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to properly use them. All sexually active adolescents should be screened annually for STDs or more often if deemed medically necessary.

STD screening and results must be documented in the medical record as well as education and treatment, if indicated. The local Health Department must be notified of all positive STDs.

Pap smear should be performed at age 18 and above. (Refer to age appropriate standardized screening form and STD/Pelvic section)

IV. HEALTH EDUCATION

ANTICIPATORY GUIDANCE/HEALTH EDUCATION

Anticipatory guidance and health education are an integral part of the screening and must be provided by the professional. Age appropriate topics/information must be presented during each screen. Providers should use oral and written information.

Specific topics discussed or written information distributed must be documented in the medical record. If the age appropriate encounter form is used, simply checking the items that apply is all that is necessary. However, any and all documentation should be dated and signed appropriately. (See Standardized Screening Forms for age appropriate health standards).

V. VISION

All children should have an eye exam using ophthalmoscope. In addition, all children should have additional vision screening that is age appropriate. This includes screening for ocular alignment, visual acuity and physical abnormalities of the eye.

(See age appropriate standardized screening forms and recommendations of TennCare EPSDT Screening Guidelines Committee and Screening Section)

The examination(s) performed and results should be recorded in the medical record. Referrals should be documented.

VI. HEARING

Significant hearing loss can be present at birth and, if undetected, will impede speech, language, and cognitive development. Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE).

Screening the hearing in infants and young children up to the age of three (3) may be accomplished using Denver noise makers, voice, etc., and subjectively by parental observation. Objective hearing measurements should be done as early as **age three years** and as indicated on the periodicity schedule. Bilateral audiometric screening should be done with pure tones of 20dB HL at 500, 1000, 2000 and 4000Hz.

Results of the screening must be recorded in the medical record indicating passed or failed. Positive screening results should lead to referral for diagnostic assessment of hearing. However, a prompt re-screening may be done prior to referral if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit. All screening and results must be documented in the medical record. (See age appropriate standardized screening form and Recommendations of TennCare EPSDT Screening Guidelines Comments).

VII. IMMUNIZATIONS

Immunizations, if needed should be given at the time of the preventive/checkup visit or at any other contract with the child.

See Recommended Childhood Immunization Schedule January - December 2000 from the American Academy of Pediatrics.

Hepatitis B may be documented as Hep. B or HBV.

Diphtheria, Tetanus and Pertussis may be documented as DTP, DTP-Hib, or DTAP-Hib, seen as Tetramune combo-which is DTP and Hib.

Hemophilus Influenza type b may be documented as Hib, DTP-Hib, or DTAP-Hib, seen as Tetramune combo-which is DTP an Hib.

Polio vaccine may be documented as OPV or IPV.

Measles, Mumps and Rubella vaccine may be documented as MMR.

Varicella Zoster vaccine may be recorded as chicken pox or Varivax. This vaccine was not mandatory until 6/30/97.

If any immunization is contraindicated at date of service, mark audit tool as contraindicated. (See age appropriate standardized screening from and Immunization Section). Mark tool N/A if immunization is not applicable at date of service.

DENTAL SCREENING

Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supportive structures. Maintenance of good dental health requires the beginning of dental care at an early age.

Although an oral screening is part of the physical examination, it does not substitute for screening examination performed by a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule. Children must be referred to a dentist for routine dental care beginning at age three (3) and yearly thereafter. However, if deemed medically necessary, a dental referral may be made at any age.

Dental inspection as well as referral and education must be documented in the medical record. (See age appropriate standardized screening form, periodicity schedule and Dental Section).

REFERRALS

Determine if the provider made any referrals for the child on the date of service and mark the appropriate box. If no referrals made please mark "none".

LEGIBILITY

Rate the legibility of the medical record according to the scale given.

Once chart audit has been completed, count all seven components and place appropriate numbers at top of audit tool.

TNAAP EPSDT Chart Documentation Forms

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) has developed EPSDT documentation forms for use in physician offices. These forms were developed with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division.

Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

Paper copies of the forms follow. Electronic copies of these forms can be obtained from the TNAAP web site at www.tnaap.org.

N B EPSDT Screening Date ___/___/200_ Member ID # ___-___-____

Newborn Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. Head circ. _____ cm Temp. _____ T R

Nutrition

- ☐ Breast _____ min. _____ times per day
- ☐ Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

Wet diapers per day _____

Strong stream (if male)? Yes No ?

Stools per day _____

WIC yes no

Problems

Constipation	Yes	No
Sleep	Yes	No
Spitting up	Yes	No
Excessive crying	Yes	No

_____

_____

_____

Hearing

Responds to sounds yes no

Newborn hearing screen:

NL Repeat not done

Vision:

Looks at parent's face yes no

Newborn Metabolic Screen

NL Repeat Pending

☐ See New Patient History Sheet

Physical Exam (undressed yes no) √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Umbilical Cord	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Circumcision	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Sleep on back
- ☐ Firm, well fitting crib mattress

Health

- ☐ ↑ feedings to 26 – 32 oz /day
- ☐ Sponge bathe
- ☐ Cord, circumcision care
- ☐ Bowel movements
- ☐ Fever

Social/Behavioral

- ☐ Who makes up family
- ☐ Support for mother
- ☐ Baby's temperament
- ☐ Cuddle, talk, rock
- ☐ Sleep

Impression

- ☐ Well Newborn
- ☐ Premature Infant
- ☐ Jaundice
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Hepatitis B #1
- ☐ RTC 1 month _____
- ☐ _____

_____

_____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID # _____

1 M EPSDT Screening Date ___/___/2000 Member ID # ___-___-____

One Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ min. q. _____ hrs.

☐ Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Colic	yes	no
Stuffy nose	yes	no
Sleep	yes	no

_____

_____

_____

Hearing

Responds to sounds yes no

Newborn hearing screen:

NI Repeat Not done

Vision:

Looks at parent's face yes no

Follows with eyes yes no

Developmental Screen

see separate form

normal abnormal

Newborn Metabolic Screen

normal repeat pending

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Umbilical Cord	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Circumcision	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

☐ Car seat, facing backwards
☐ Smoke free environment
☐ Smoke detectors in home
☐ Hot water < 120 degrees
☐ No bottle propping
☐ Sleep on back
☐ Crib Safety

Health/Nutrition

☐ If bottle fed, 26-32 oz/day
☐ If breast fed, nurses 8-10 times/day
☐ Delay solids
☐ Bowel movements
☐ Strong urinary stream, if male
☐ Fever

Social/Behavioral

☐ Temperament
☐ Sleep
☐ Talk to baby
☐ Support for mother
☐ Day care plans yes no

Impression

☐ Well Baby
☐ _____
☐ _____

Plan/Referrals

☐ Hepatitis B Vaccine
☐ Vaccine Information Sheet
☐ One month Handout sheet
☐ RTC at 2 months _____
☐ _____
☐ _____
☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID # _____

2 | M EPSDT Screening Date ___/___/200 Member ID# ___-___-____

2 Month Visit

Name _____ Birth Date _____ Historian _____

ge _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ times per day

☐ Formula _____ oz . per day

Brand _____

With iron? Yes No

☐ Cereal Yes No

Water: city well spring bottled

WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

_____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Colic	yes	no
Stuffy nose	yes	no
Sleep	yes	no
Diaper rash	yes	no

_____

_____

Hearing

Responds to sounds yes no

Smiles and laughs yes no

Newborn hearing screen:

normal Repeat Not done

Vision:

Looks at parent's face yes no

Follows with eyes yes no

Developmental Screen*

normal abnormal

Newborn Metabolic Screen

normal abnormal pending

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

☐ Car seat, facing backwards
☐ Smoke free environment
☐ Smoke detectors in home
☐ Hot water < 120 degrees
☐ No bottle propping
☐ Sleep on back
☐ Crib safety
☐ Rolling over, prevent falls

Health/Nutrition

☐ If bottle fed, 26-32 oz/day
☐ If breast fed, nurses 8-10 times/day
☐ Delay solids
☐ Bowel movements
☐ Strong urinary stream, if male
☐ Fever

Social/Behavioral

☐ Temperament
☐ Sleep
☐ Talk to baby
☐ Support for mother
☐ Day care plans yes no

Impression

☐ Well Baby, nl. growth and development
☐ _____
☐ _____
☐ _____

Plan/Referrals

☐ DTaP, IPV, Hib, Hep B, PCV-7
☐ Vaccine Information Sheet
☐ Acetaminophen _____ mg. q 4 hrs.
☐ Two month Handout sheet
☐ RTC at 4 months _____
☐ _____
☐ _____
☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID # _____

4	M

EPSDT Screening Date Date

		/			/	2	0	0	

Member ID #

			–			–				

4 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs._____oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast_____times per day.

☐ Formula _____ oz . per day

Brand _____
With iron? Yes No
Water: city well spring bottled
Cereal/baby food Yes No
WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Sleep	yes	no
Diaper rash	yes	no

_____

_____

Hearing/Speech

Responds to sounds	yes	no
Babbles and coos	yes	no

Vision:

Looks at parent's face	yes	no
Follows with eyes	yes	no

Developmental Screen*

normal abnormal

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Fall prevention
- ☐ Bath safety
- ☐ No baby walkers
- ☐ Child proof home

Health/Nutrition

- ☐ If bottle fed, 26-32 oz/day
- ☐ If breast fed, nurses 8-10 times/day
- ☐ Introduce solids
- ☐ Avoid honey
- ☐ Teething

Social/Behavioral

- ☐ Temperament
- ☐ Sleep, bedtime routine
- ☐ Talk, read to baby
- ☐ Family support
- ☐ Day care yes no

Impression

- ☐ Well Baby, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ DTaP, IPV, Hib, Hep B, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Four month Handout sheet
- ☐ RTC at 6 months _____
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID#

6 | M

EPSDT Screening Date ☐☐/☐☐/2 0 0☐

Member ID# ☐☐☐–☐☐☐–☐☐☐☐

6 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs._____oz. Length _____ inches Head circ. _____ cm Temp. _____T R

Nutrition

☐ Breast_____times per day.

☐ Formula _____oz. per day

Brand_____

With iron? Yes No

Water: city well spring bottled

Cereal/baby food Yes No

Servings per day _____

WIC: yes no

History Update

Are there any changes in your family history? No Yes

_____

Has the patient had any new problems or illnesses since the last visit?

No Yes

_____

Problems/Concerns

Constipation yes no

Sleep yes no

Diaper rash yes no

_____

Hearing/Speech

Responds to sounds yes no

Jabbers and laughs yes no

Vision:

Looks at parent's face yes no

Follows with eyes yes no

Developmental Screen*

normal abnormal

Lead Risk Factors*

yes no

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

☐ Car seat, facing backward
☐ Smoke detectors in home
☐ Hot water < 120 degrees
☐ Rolling over, fall prevention
☐ No baby walkers
☐ Child proof home
☐ Always supervise bath
☐ Sun exposure

Health/Nutrition

☐ Continue formula or breast milk
☐ Introduce meats, finger foods
☐ Introduce cup, juice
☐ Avoid honey
☐ Teething / clean teeth
☐ No bottle in bed or bottle propping

Social/Behavioral

☐ Temperament
☐ Sleep, bedtime routine
☐ Talk, read to baby
☐ Family support
☐ Day care yes no

Impression

☐ Well Baby, normal growth and development

☐ _____

☐ _____

Plan/Referrals

☐ DTaP, PCV-7, Hib, Hep B, IPV
☐ Vaccine Information Sheet
☐ Acetaminophen _____mg. q 4 hrs.
☐ Six month Handout sheet
☐ RTC at 9 months
☐ Fluoride gtts. 0.25 mg daily

☐ _____

☐ _____

☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ☐☐☐☐☐☐☐☐☐☐☐☐

9 | M

EPSDT Screening Date ____/____/2000

Member ID# ____-____-____

9 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ times per day.

☐ Formula _____ oz. per day

Brand _____

With iron? Yes No

Water: city well spring bottled

Baby food _____ servings/day

Table foods Yes No

WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Responds to sounds yes no

Imitates speech yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors*

yes no

Lab Tests

Hgb _____

_____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backward
- ☐ Smoke detectors in home
- ☐ Smoke free environment
- ☐ Hot water < 120 degrees
- ☐ Fall prevention
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Always supervise bath
- ☐ Sun exposure

Health/Nutrition

- ☐ Continue formula or breast milk
- ☐ Introduce table, finger foods
- ☐ Choking prevention
- ☐ Avoid honey
- ☐ Introduce cup, weaning
- ☐ Teething / clean teeth
- ☐ No bottle in bed or bottle propping

Social/Behavioral

- ☐ Exploring; set consistent limits
- ☐ Sleep, bedtime routine
- ☐ Talk, read to baby
- ☐ Family
- ☐ Day care

Impression

- ☐ Well Baby, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Hep B, Hib, DPaT, IPV, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____ mg. q 4 hrs.
- ☐ Nine month Handout sheet
- ☐ RTC at 12 months
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# _____

1	2	M

EPSDT Screening Date Date ____/____/2 0 0 ____

Member ID# ____ ____ ____ – ____ ____ – ____ ____ ____ ____

12 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 2-4 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb(if not done at 9 mo)_____

Lead level_____

_____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward if > 20#
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaning
- ☐ Introduce whole milk from cup
- ☐ Limit juice, milk intake
- ☐ Changes in appetite
- ☐ Introduce table, finger foods
- ☐ Choking prevention
- ☐ Teething / clean teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Sleep, bedtime routine
- ☐ Talk, read to baby
- ☐ Family
- ☐ Day care yes no

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Varicella, PCV-7, Hib, Hep B, DTaP, IPV, MMR
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Twelve month Handout sheet
- ☐ RTC at 15 months
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

1	5	M

EPSDT Screening Date ____/____/2 0 0 ____

Member ID# ____-____-____

15 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 3-6 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb(if not done at 9 mo)_____

Lead level _____

_____

* separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward if > 20#
- ☐ Smoke detectors,no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaned from bottle?
- ☐ Whole milk until age two
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Offer variety of foods
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Sleep, bedtime routine
- ☐ Talk, read to child
- ☐ Family

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ MMR, Hib, DTaP,IPV, Varicella, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Fifteen month Handout sheet
- ☐ RTC at 18 months
- ☐ Fluoride gtts. O.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# _____

1	8	M

EPSDT Screening Date ____/____/2000

Member ID# ____-____-____

18 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 15-20 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests (record result from visits at 9-12 months, if done)

Hgb _____

ad level _____
see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward
- ☐ Smoke detectors, no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaned from bottle?
- ☐ Whole milk until age two
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Offer variety of foods
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Time out, tantrums
- ☐ Toilet training
- ☐ Talk, read to child
- ☐ Family
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ DTaP, IPV, Hib, Hep B, MMR , PCV-7, Var.
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Eighteen month Handout sheet
- ☐ RTC at 2 years
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# _____

2 Y EPSDT Screening Date ___/___/2000 Member ID# ___-___-____

Two Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Weaned from bottle? yes no

Appetite: good variable picky

fruits _____

veggies _____

meats _____

bread _____

Water: city well spring bottled

WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Has the patient had any new problems or illnesses since the last visit?

Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no

2-3 word sentences yes no

Vision:

Sees distant objects well? yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb _____

Lead level _____

(Hgb required at 9 mos. Test only if not done previously or if abnl. Lead level required at 12 & 24 mos. for TNCare.)

Cholesterol _____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward
- ☐ Smoke detectors, no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home, supervision
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk from cup
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set limits, time out
- ☐ Praise good behavior
- ☐ TV limits
- ☐ Read to child
- ☐ Toilet training
- ☐ Sleep, bedtime routine
- ☐ Family
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ DTaP, IPV, HepB, HIB, MMR, Var, PCV-7
- ☐ Two year handout sheet
- ☐ RTC at 3 years
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ____________

3 Y EPSDT Screening Date ___/___/2000 Member ID# ___-___-____

Three Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____lbs Length _____ inches BP _____ Temp. _____ T R O

Nutrition

Lowfat milk, cup only yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
bread _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____
↑ heart disease < 55 No Yes
↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Talks well ? yes no
Easy to understand ? yes no

Vision:

Sees small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb _____

Lead level _____
(Hgb required at 9 mos. Test only if not done previously or if abnl. Omit lead if normal at 24 months& low risk)

Cholesterol _____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car safety seat, back seat safest
- ☐ Smoke detectors, no smoking in home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Firearm safety
- ☐ Outdoor safety, supervision
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk from cup
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Low fat foods and healthy snacks
- ☐ Brush teeth, see dentist

Social/Behavioral

- ☐ Discipline, time out
- ☐ Praise good behavior
- ☐ TV limits, read to child
- ☐ Toilet training
- ☐ Self help skills
- ☐ Curiosity about sex
- ☐ Family
- ☐ Friends and playmates
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ DTaP, IPV,HepB, Hib, MMR,Var, PCV-7
- ☐ Three year handout sheet
- ☐ RTC at 4 years
- ☐ Fluoride gtts. 0.5 mg daily
- ☐ Chewable Vitamins with Iron
- ☐ Dental check-up
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ___-___-____

4	Y

EPSDT Screening Date ☐☐/☐☐/200☐ Member ID# ☐☐☐-☐☐-☐☐☐☐

Four Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T R O

History Update
Changes in your family history?
No Yes

_____
Has the patient had any new problems or illnesses since the last visit? No Yes

_____
FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Nutrition
Appetite: good variable picky
Water: city well spring bottled
WIC: Yes No

Hearing/Speech
Hears well ? yes no
Talks well ? yes no
Easy to understand ? yes no
Hearing screening test
normal abnormal unco-op

Vision:
Notices small objects yes no
Vision screening test:

L _____ R _____

Developmental Screen*
normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests
Hgb _____

Lead level _____
(Hgb required at 9 mos. Test only if not done previously or if abnl. Omit lead level normal at 24 mos. & low risk.)

Cholesterol _____
*see separate form

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety
- ☐ Smoke detectors
- ☐ No smoking in home
- ☐ Car safety seat, back seat safest
- ☐ Booster seat > 40 #
- ☐ Bike helmet
- ☐ Water safety, swimming lessons
- ☐ Firearm safety
- ☐ Outdoor safety, supervision
- ☐ Sunburn prevention

Health/Nutrition
- ☐ Low fat milk
- ☐ Encourage fruits and vegetables
- ☐ Brush teeth, see dentist
- ☐ Encourage active play

Social/Behavioral
- ☐ Discipline, time out
- ☐ Praise good behavior
- ☐ TV limits, read to child
- ☐ Dresses self, helps at home
- ☐ Curiosity about sex
- ☐ Family
- ☐ Friends and playmates
- ☐ Day care, pre-school

Impression
- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ DTaP, IPV, HepB, Hib, MMR, Var
- ☐ Four year handout sheet
- ☐ RTC at 5 years
- ☐ Fluoride gtts. 0.5 mg daily
- ☐ Chewable Vitamins with Iron
- ☐ See dentist
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ☐☐☐☐☐☐☐☐☐☐☐☐

5 Y | EPSDT Screening Date ___/___/200 | Member ID # ___-___-____

FiveYear Preventive Visit and Kindergarten Check-up

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Height _____inches Weight _____ lbs. Blood pressure _____ Temp. _____T R O

History Update

Changes in family history? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes
Has the patient had any new problems or illnesses since the last visit? No Yes

_____

Problems / Parental Concerns

_____

_____

Nutrition

Appetite: good variable picky
Water: city well spring bottled
WIC: Yes No

Hearing/Speech

Problems with speech? yes no
Hearing screen normal abnormal

Vision:

L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____

Muscle balance pass fail

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb_____

Lead level _____ Omit lead level if normal at 24 mos. & low risk.
Cholesterol _____
Urinalysis (required at age five)
☐ back for results
☐ see separate form

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

☐ Smoke detectors, no smoking in home
☐ Booster seat > 40 #, < 70 #
☐ Bike helmet, street safety
☐ Water safety, swimming lessons
☐ Firearm safety
☐ Outdoor safety, supervision
☐ Sunburn prevention

Health/Nutrition

☐ Low fat milk
☐ Encourage fruits and vegetables
☐ Brush teeth, see dentist
☐ Encourage active play

Social/Behavioral

☐ Give choices, encourage independence
☐ Praise good behavior
☐ Talk, time out, lose privileges
☐ TV limits, read with child
☐ Questions about sex
☐ Family relationships
☐ Friends and playmates
☐ Pre-school, school readiness

Impression

☐ Well Child, normal growth and development
☐ _____
☐ _____

Plan/Referrals

☐ Immunizations current yes no
☐ DTaP, IPV, MMR _____
☐ Vaccine Information Sheet
☐ Five year handout sheet
☐ See dentist
☐ RTC at _____ years
☐ _____
☐ _____
☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# _____

6	10	Y

EPSDT Screening Date | | | / | | / | 2 | 0 | 0 | | Member ID# | | | | – | | | – | | | | |

6 to 10 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update

Changes in your family history? No Yes

_____

Has the patient had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Nutrition

Low fat milk ?	yes	no
Variety of fruits/vegetables?	yes	no
Eats breakfast?	yes	no
[illegible] supper with family?	yes	no

[illegible]aring (test at age 10 or every 5 yrs if nl)
Hearing screen pass fail
Date _____

Vision (test every two years)
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____
☐ Wears glasses, sees eye specialist

School Grade _____
Problems? Yes No

_____

_____

TB Risk Factors* yes no
(see separate form)
IPPD result _____

Lab Tests

Hgb _____
If abnormal or not done at age 5 years.

Cholesterol _____
If [illegible] factors and not done at age 5 yrs.
U[illegible]ysis (If abnl. or not done at 5 yrs.)
see back for results
*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage	____
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage	____
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Smoke detectors, no smoking in home
- ☐ Buckle up!
- ☐ Booster seat < 58", < 70#
- ☐ Bike helmet, street safety
- ☐ Water safety, swimming lessons
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk and snacks
- ☐ Encourage fruits and vegetables
- ☐ Brush teeth, see dentist
- ☐ Encourage sports, active play

Social/Behavioral

- ☐ School adjustment, performance
- ☐ Sports and hobbies
- ☐ Limit TV, computer games
- ☐ Give choices, encourage independence
- ☐ Set limits, provide consequences
- ☐ Privacy, personal hygiene
- ☐ Puberty changes and ? about sex
- ☐ Family relationships
- ☐ Friends and schoolmates
- ☐ Dealing with strangers
- ☐ Developmental/Behavioral Screen*

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# | | | | | | | | | | | |

11	14	Y

EPSDT Screening Date ___/___/200_

Member ID# _____-_____-_____

11 to 14 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update
Changes in your family history?
No Yes

_____

Have you had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Concerns

_____

_____

Nutrition

Low fat milk ?	yes	no
Variety of fruits/vegetables?	yes	no
Eats breakfast?	yes	no
Eats supper with family?	yes	no

Hearing (age 14 and every 5 years if nl)
Hearing screen pass fail
date _____

Vision: (test every two years)
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____
☐ Wears glasses, sees eye specialist

School Grade _____
Problems? Yes No

_____

_____

TB Risk Factors yes no
(see separate form)
IPPD result _____

Lab Tests
Hgb _____
If abnormal or not done at age 5 years.

Cholesterol _____
Every 5 years if risk factors & previously normal.
Urinalysis (If abnl. or not done at 5 yrs.)
☐ see back for results

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage	____
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage	____
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐
Pelvic	☐

Safety
- ☐ Smoke detectors, no smoking in home
- ☐ Buckle up!
- ☐ Bike helmet, street safety
- ☐ Swimming, water safety
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition
- ☐ Low fat milk and snacks
- ☐ Healthy food choices
- ☐ Brush teeth, see dentist
- ☐ Acne
- ☐ Encourage sports, exercise
- ☐ Sports form attached yes no

Social/Behavioral
- ☐ School adjustment, performance
- ☐ Sports and hobbies
- ☐ Limit TV, computer games
- ☐ Give choices, encourage independence
- ☐ Set limits, provide consequences
- ☐ Saying no to tobacco, drugs, alcohol
- ☐ Puberty changes and ? about sex
- ☐ Periods (girls) LMP _____
- ☐ Friends, boy/girl friends
- ☐ Abstinence, birth control
- ☐ Developmental/Behavioral Screen (see separate form)

Impression
- ☐ Well Child/Adolescent, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.
☐ See back for additional documentation

Provider ID# _____

15	20	Y

EPSDT Screening Date

Member ID#

15 to 20 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update
Changes in your family history?
No Yes

Have you had any new problems or illnesses since the last visit? No Yes

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Concerns

Nutrition
Low fat milk ? yes no
Variety of fruits/vegetables? yes no
breakfast? yes no
[illegible] supper with family? yes no

Hearing (age 14 and every 5 years if nl)
Hearing screen pass fail
date _____

Vision: (test every two years)
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____
☐ Wears glasses, sees eye specialist

School Grade _____
Problems? Yes No

TB Risk Factors yes no
(see separate form)
IPPD result _____

Lab Tests
Hgb _____
At age 15 or if risk factors
Cholesterol _____
Every 5 years if risk factors & previously r[illegible]al.
U[illegible]lysis (at age 15 or if risk factors)
☐ see back for results
☐ STD screening, PAP (see back)

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage	____
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage	____
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐
Pelvic	☐

Safety
- ☐ Smoke detectors
- ☐ Driving and automobile safety
- ☐ Bike safety, helmets
- ☐ Swimming, water safety
- ☐ Firearm safety
- ☐ Sunburn prevention, tanning beds

Health/Nutrition
- ☐ Healthy food choices, Ca++ intake
- ☐ Concerns about weight, body image
- ☐ Periods (girls) LMP _____
- ☐ Breast/Testicular Self Exam
- ☐ Acne
- ☐ Encourage sports, exercise
- ☐ Sports form attached yes no

Social/Behavioral
- ☐ School adjustment, performance
- ☐ Plans for work and further education
- ☐ Friends and fun
- ☐ Tobacco use
- ☐ Drug and alcohol use
- ☐ Boy or girl friends
- ☐ Abstinence, birth control
- ☐ STDs
- ☐ Family relationships
- ☐ Developmental/Behavioral Screen (see separate form)

Impression
- ☐ Well Adolescent, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ Meningococcal vaccine, Adult dT
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.
☐ See back for additional documentation

Provider ID#

Name_____

Lead Poisoning Risk Assessment Questions

These questions must be asked at all EPSDT (TNCare) physical exams from 6 t0 72 months and are recommended for all 12 month and 2 year exams.

DATE										
1. Does your child live in or regularly visit a house built before 1950? (This could include a day care center, baby sitter's home or the home of a relative.)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2. Does your child live in or regularly visit a house built before 1978 with recent, ongoing or planned renovations or remodeling (within the past 6 months)?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Does your child have a playmate or sibling that has, or did have lead poisoning?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Tuberculosis Risk Assessment Questions

These questions must be asked at all EPSD&T (TNCare) physical exams beginning at one year of age. They should be asked at all new patient physicals > one year, and at the one and five year check-ups and every 3-5 years.

DATE										
1. Is your child in close contact with a person with tuberculosis?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2. Is your child foreign born (esp. Asian, African, Latin American), a refugee or a migrant?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Does your child live in a community in which there is a high risk for tuberculosis?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4. Does your child have a medical condition that suppresses the immune system?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
5. Is your child on any medications or treatments that suppress the immune system?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
6. Does your child have HIV infection or is he or she considered at risk for HIV infection?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
7. Is your child exposed to any of the following: HIV infected persons, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illegal drugs, imprisoned adolescents or adults, migrant farm workers	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

These questions follow the guidelines of the American Academy of Pediatrics and meet the requirements of the Tennessee Bureau of Tenncare.

STATE OF TENNESSEE
Bureau of TennCare
MCO EPSDT Coordinators
as of October 2002

TLC	Ms. Francine Brown 1407 Union Avenue Suite 200 Memphis, TN 38104	Phone: 901-725-7100, Ext. 3411 Fax: 901-725-2846 E-mail: fbrown@mmcc-tlc.com
PHP	Ms. Peggy McCurry or Ms. Mary Cogar 1420 Centerpoint Blvd. Knoxville, TN 37932	Phone: 865-470-7589 865-670-7338 Fax: 865-470-7404 E-mail: Pamccurr@covhlth.com Mdcogar@covhlth.com
Universal	Ms. Peggy Payne 1600 East Hill Street Spring Hill, CA 90806	Phone: 562-981-7509 Fax: 714-539-6791 E-mail: ppayne@universalcare.com
JDH	Ann Bly 408 North Cedar Bluff Road #400 Knoxville, TN 37772	Phone: 865-769-1599 Fax: 865-690-1941 E-mail: blyanng@johndeere.com
BHP	Ms. Marie Hawranko 300 Oxford Drive Monroeville, PA 15146	Phone: 412-856-5117 Fax: 412-380-7372 E-mail: mhawra@trhp.com
OmniCare	Ms. Margaret Lynch 1991 Corporate Avenue 5th Floor Memphis, TN 38132-1702	Phone: 901-348-3324 Fax: 901-348-3399 E-mail: mlynch@ochptn.com
VHP	Ms. Sela Desoto 215 Centerview Drive Suite 300 Brentwood, TN 37027	Phone: 615-782-7810 Fax: 615-782-7822 E-mail: sdesoto@vhptn.com
BCBST	Ms. Donna Roddy 801 Pine Street – 2G Chattanooga, TN 37402	Phone: 423-752-6458 Fax: 423-763-3248 E-mail: Donna_roddy@bcbst.com
XHP	Ms. Julia Patton 3402 West End Avenue Suite 470 Nashville, TN 37203-1069	Phone: 615-463-1666, Ext. 2277 Fax: 615-279-1253 E-mail: jpatton@xhtmail.com

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DRAFT

TNAAP
Website Recommendation

The following is a draft table of contents of TNAAP's recommended EPSDT website. The contents will include an expanded version of the materials included in the educational materials, links to other key EPSDT websites and information about EPSDT training resources.

DRAFT

TNAAP
Early Periodic Screening Diagnosis and Treatment (EPSDT)
On-line Guide

Draft Table of Contents

- Laboratory
- Immunizations
- Hearing
- Vision
- CPT Modifiers

Documentation Forms/Questionnaires

- TNAAP EPSDT chart documentation forms
- Lead Screening forms
- TB Screening forms
- History?

TNAAP as a resource for training programs

- Training in your office
- Training in your community
- Independent learning materials (videos, CDs, etc.)

Legal

- References to legal descriptions of EPSDT
- Legal actions against the state

Health Departments

- Why the Tennessee has health departments performing EPSDT screens
- Health Department Contact information

Other EPSDT Resources

- Profession articles
- Other web sites with EPSDT information

Ask us an EPSDT questions (e-mail link)

Attachment III
Outline of Coding Educator Recruitment Activities

Outline of Coding Educator Recruitment Activities

Two different rounds of advertisements were placed in the classified section of the Knoxville News Sentinel and the Tennessean on the following dates:

- Knoxville News Sentinel: 07/21/02 and 10/13/02
- Tennesseean: 07/21/02 and 11/24/02 and 12/01/02

The job description was posted on the following web site:

- Tennessee Health Information Management Association (THIMA) Web site, August, 2002

Contact was made with the following organizations to get the word out to students and or staff:

- Colleges:
  - Volunteer State Community College, Gallatin, TN
  - Roane State Community College, Knoxville, TN

- Professional Organizations:
  - Cumberland Pediatric Foundation
  - Nashville Medical Society
  - Various local chapters of the American Association of Coders

A total of 14 resumes were received.

Approximately ten telephone interviews were conducted and five in-person interviews were conducted.

Jacque Clouse, RHIT, CCP, has been hired for this position and will begin work with TNAAP on February 3, 2003.

Attachment IV
Newsletter Articles

the Tennessee Pediatrician

THE OFFICIAL PUBLICATION OF THE TENNESSEE CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY

FALL 2002

RSV PROPHYLAXIS-
ADMINISTRATIVE ROADBLOCKS TO TREATMENT

Suzanne Berman, M.D., FAAP
Chair, TNAAP Palivizumab-RSV Taskforce
sberman@plateaupediatrics.com

Lower respiratory tract infection with respiratory syncytial virus causes significant morbidity and mortality amongst the children of Tennessee. Monoclonal antibody prophylaxis with palivizumab (Synagis) has been shown to improve clinically meaningful outcomes for children who are at risk. Both the 1998 American Academy of Pediatrics Policy Statement and the 2000 Redbook recommend that infants born between 32-5 weeks gestation be considered for palivizumab prophylaxis if they have other risk factors; unfortunately, while the Policy specifically identifies those risk factors, e.g. day care attendance, crowded living conditions, and passive smoke exposure, the Red Book merely references them in general, stating that, "given the large number of patients born between 32 and 35 weeks gestation and the cost of the drug, the use of palivizumab...should be reserved for infants with additional risk factors". New data expands the "at risk" population to include children with congenital heart disease and argues that the yearly period of prophylaxis be flexible, determined by local epidemiologic data.

Payers in Tennessee have had a variable response to claims made for prophylaxis with this drug. One appears to have made it a policy to deny claims for palivizumab if the child was born after 32 weeks gestation, regardless of

continued on page 3...

Recertification: What is Really Happening?

Dave Tayloe, Jr., MD, FAAP
Chair, AAP District IV
919-580-7209; dtayloe@aap.org

Beginning January 1, 2003, pediatricians wishing to recertify with the American Board of Pediatrics (ABP) will follow a new protocol, which the ABP has named the Program for Maintenance of Certification in Pediatrics (PMCP). The PMCP is a four-part format that will be completely phased in by 2010. The four parts require physicians to provide evidence of:

1. Professional Standing (state licensure);
2. Lifelong Learning and Self-assessment;
3. Cognitive Expertise (closed-book secure examination); and
4. Satisfactory Performance in Practice.

By 2010, the four-part recertification process will be the norm for all pediatricians. Parts 1 and 3 will be required of pediatricians needing to recertify in 2003. Those pediatricians will be sent notices and details of the PMCP in September 2002. Parts 2 and 4 will be developed and phased in over time. The American Academy of Pediatrics (AAP) sponsors educational activities through Pedialink, PREP the Continuum (Pediatric Review and Education Program), and eQIPP (Education in Quality Improvement for Pediatric Practice). Programs that will help pediatricians prepare for Part 3, and fulfill the requirements for Parts 2 and 4.

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INSIDE

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Next Issue: Winter 2003

NEWSLETTER EDITORS
Catherine M. Fenner
Joseph F. Lentz, M.D.

President's Report

John C. Ring, MD, FAAP
50 N Dunlap, Memphis 38103
(w) 901-572-3292; jring@utmem.edu

To paraphrase the Chinese, we are truly "blessed" by the "interesting times" in which we Tennesseans find ourselves living today! The AAP Annual Chapter Forum in September brought the leadership of our organization together once again to discuss the future direction of the Academy. While it would be an overstatement to say that consensus was reached on every issue, I was proud to be a member of a group that consistently, candidly, articulately, and collegially advocated what's best for children and their providers. The AAP National Conference and Exposition in October provided superb CME focused towards practicing pediatricians and gave members ample access to Academy policymakers regarding both patient care and non-patient care issues alike.

Closer to home, your Chapter partnered with the Children's Emergency Care Alliance (CECA) in presenting a very successful CME meeting in Knoxville, "Advancing the Frontiers of Pediatric Emergency Care". Our EPSDT Contract with the TennCare Bureau has benefited both members and the State through the development of documentation templates that facilitate care, confirm compliance with external regulation, and, hopefully, will improve provider reimbursement. Our Pediatric Practice Managers' Network continues to grow, providing expert education and support to these key ancillary personnel. The Chapter supported the submission of several CATCH grants this cycle; the wealth of ideas presented in these submissions was matched only by the dire needs they addressed. The recent state and federal elections also present us with important challenges and opportunities.

Our Governor-Elect, his administrative appointees, and the members of the General Assembly also live in "interesting times". We need to make certain that they understand there is no policy issue of greater importance today than improving the health of the children of Tennessee. As a leading voice for children and their physician-providers in this state, the Tennessee Chapter of the American Academy of Pediatrics / Tennessee Pediatric Society recognizes that a point of crisis has been reached. In a letter to Mr. Brecesen, we emphasized the following concerns:

1. Every child deserves health care sufficient to maximize their potential for growth and development. The American Academy of Pediatrics has defined the standard of care that children should receive in order to achieve that goal. It is illogical, short-sighted in the extreme, and perhaps immoral to offer any less. As citizens, physicians, and, in many instances, parents, we can identify no valid rationale to exclude any child from such coverage.
2. Rates of compensation for children's health care remain unrealistically low. In many instances, pediatricians lose money providing necessary services to children; this is particularly true when it comes to preventive care. Adequate coverage cannot continue to be an underfunded mandate in any part of the richest country in the world.
3. Multiple obstacles exist to participation in TennCare, for both our patients and their providers. These obstacles have lead, inevitably, to the development of primary and subspecialty care networks that are woefully inadequate to treat the children for whom they are responsible. These obstacles now threaten to disenfranchise our patients regardless of their

continued on page 5...

RSV...continued from page 1

risk factors; even documentation that the infant has chronic lung disease has not always lead to approval. Other insurers have often approved payment for the drug, especially if the individual case is made to the payer's representative by the prescribing physician. Variable responses exist even within the programs administered by a single payer. A sound scientific rationale for denials is often not forthcoming.

The Tennessee Chapter of the American Academy of Pediatrics/Tennessee Pediatric Society is committed to providing children with all of the health care services that they require. We also want to provide these services in a cost-effective manner and we integrate that consideration into every management decision that we make; that is especially true in Tennessee where resources for health care remain limited. As busy practitioners, we rely heavily upon technical recommendations from the AAP, which we regard as the single best source for health care information about children. Thus, we are concerned that some payers are compromising the care which our patients deserve, placing us in the untenable position of having to deny palivizumab prophylaxis or accept the financial burden ourselves for its provision when the family cannot pay. It is possible that we will begin to encounter similar difficulties with influenzae vaccination.

We need help from our members, as follows:

1. Share your experiences with us in detail, especially those instances in which you feel claims were wrongfully denied.
2. Write to the Medical Directors of your major payers, encouraging them to follow AAP Guidelines (and thanking them if they are already doing so).
3. Encourage the AAP Committee on Infectious Diseases to keep its membership aware of changing recommendations in a timely fashion, especially as they pertain to cost-efficacy data. Make them aware, too, of how apparent inconsistencies between recommendations in the Policy and the Red Book complicate reimbursement for palivizumab prophylaxis for children born between 32-5 weeks gestation.

If you are interested in helping with palivizumab advocacy or if you are having problems with particular insurers, please feel free to contact me.

AAP HIPAA Privacy Manual and Other HIPAA Resources

The AAP HIPAA Privacy Manual has been updated to incorporate the most recent changes in the Privacy Rule (published on August 14, 2002). Don't miss this tremendous resource! The manual provides step-by-step instructions for evaluating your practice and implementing necessary requirements associated with privacy. The manual includes sample checklists, forms, vendor contract templates and more.

To download the HIPAA Privacy Manual go to www.aap.org/moc and log-in using your AAP Member ID # and password (typically your last name up to 12 characters). Click on HIPAA (left side of screen) and select Updated HIPAA Privacy Manual.

The Office of Civil Rights (OCR) released "Guidance Explaining Specific Aspects of the Privacy Rule" on December 4, 2002. OCR is the government agency charged with enforcing the privacy regulation and this document provides background information and further clarification regarding their expectations. You can review this document at: www.hhs.gov/ocr/hipaa/privacy.html.

Also, check out the TNAAP website (www.tnaap.org) for links to other useful websites for HIPAA information. Remember that you must be in compliance with the privacy requirements by April 14, 2003.

HIPAA Updates

Have you been receiving our HIPAA updates via e-mail? During the last few months, you should have received email communications regarding:

- Filing an extension for "Transactions and Code Sets" (the deadline was October 15, 2002)
- Information about the revised final "Privacy Rule", and
- Notices about HIPAA round table conference calls with the Center for Medicare and Medicaid Services (CMS)

If you did not receive these communications, chances are we do not have your email. Please forward your e-mail address to the Chapter office at tnaap@aol.com.

Getting a new computer this holiday season?

We would like your old one! If your "old" computer is less than 4 years old, and you want to help our new Foundation (more on that in the winter newsletter) while getting a tax deduction in 2003, please contact our Program Director, Patrice, at 615-599-6359 or patricetnaap@comcast.net.

EPSDT Forms Endorsed by TNAAP

TNAAP and Blue Cross Blue Shield of Tennessee have partnered to develop Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation forms. These forms were created with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division.

Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

The most recent forms more accurately reflect the specific requirements within each age group and more closely follows the "work flow" of the physical. Many offices have found using different colors of paper for each age group to be very helpful.

Electronic copies of these forms can be found on our web site at www.tnaap.org. We hope you will find these useful. We will continually be striving to improve the forms so if you have suggested changes, additions or questions, please contact our EPSDT Director, Ruth Allen, at ruthieallen@yahoo.com or at 865-927-3030.

Visit our web site
www.tnaap.org

Welcome New Members

George A. Adams, Jr, DDS	Nashville
Frank H. Alden, DDS	Johnson City
John T. Algren, MD	Nashville
Youhanna S. Al-Tawil, MD	Knoxville
Judith Deane Anderson, MD	Nashville
Ellen Andrews, MD	Knoxville
Sandra Ruth Arnold, MD	Memphis
John T. Beuerlein, MD	Knoxville
Bradley P. Carter, MD	Memphis
Farah L. Cassis, MD	Nashville
Ricardo Causo, MD	Chattanooga
Jason Troy Cheney, MD	Oak Ridge
Caroline H. Chester, MD	Nashville
Roger Allen Coffman, MD	Chattanooga
Merri Shaw Collins, MD	Franklin
Cathy A. Dailey, DO	Clarksville
Michelle Lee Davenport, MD	Johnson City
Andrew Davidoff, MD	Memphis
Elizabeth Ponder Dykstra, MD	Nashville
Jennifer Stone Erdin, MD	Memphis
Emad Abdel Fattah, MD	Union City
Deborah Maria Fernandes, MD	Dyersburg
Roy Anthony Friddell, MD	Chattanooga
R. James Garrison, MD	Murfreesboro
George Walden Garriss, III, MD, MS	Brentwood
Javel M. Granados, MD	Collierville
Sheldon M. Graves, DDS	Memphis
Veronica L. Gunn, MD	Nashville
Scott Osborn Guthrie, MD	Hendersonville
Mark Edward Halstead, MD	Nashville
Rodney Mack Hamilton, MD	Brentwood
Julie K. Hudson, MD	Nashville
David Gordon Johnston, MD	Memphis
Jeanie Jung, MD	Chattanooga
Stuart J. Kaplan, MD	Memphis
John Austin Kirby, MD	Jefferson City
Tammy Lin Kitchens, MD	Johnson City
Kelly Lynn Kriwanek, MD	Memphis
Melissa Lorraine Lambert, MD	Nashville
Aubrey Lamptey, MD	Hartsville
Tiffany P. Landon, MD	Columbia
Christopher R. Ledes, MD	Johnson City
Suzanne Marie Lopez, MD	Memphis
Jeff Mann, DO	Paris
Allison S. McBride, MD	Nashville
Joshua M. McCollum, MD	Murfreesboro
Steven J. McElroy, MD	Nashville
Mary Kathryn McNeal, MD	Dickson
Martha Miller, MD	Memphis
Tracie Lynn Overbeck, MD	Memphis
Keith Bennett Owen, MD	Memphis
Lea Kristin Parsley, MD	Chattanooga
Sara Fletcher Patterson, MD	Nashville
Aurelia Radulesca, MD	Morristown
Vlad Radulesca, MD	Tazewell
Alice M. Rothman, MD	Nashville
Dawn Heather Scott, MD	Memphis
Josh Shook, MD	Knoxville
Maria Stephan, MD	Knoxville
Stephanie Howard Stovall, MD	Memphis
J. Tyson Sullivan, MD	Lebanon
Barbara Summers, MD	Knoxville
Jeffrey David Thompson, MD	Memphis
Mary Olivia Titus, MD	Nashville
Penny J. Walsh, MD	Memphis
Travis Thomas Walters, MD	Nashville
Sally Ammon Watson, MD	Nashville
Gene L. Whitington, MD	Memphis
Mark Alan Williams, MD	Memphis
Stacey Marie Williams, MD	Nashville
Clifton W. Woolley, MD	Memphis
Thomas Zerfoss, MD	Nashville

Recertification...continued from page 1

If you are a pediatrician needing to recertify in 2003, you may access the ABP website at www.abp.org, or contact the ABP at pmcp@abpeds.org. You will need to successfully complete parts 1 and 3 during calendar year 2003, to avoid a lapse in certification. The ABP has posted its Knowledge Self-assessment on its website to help pediatricians prepare for the types of questions and computer testing format that will be used for the closed-book proctored exam. You can register for the PMCP through the ABP website starting in January 2003. The registration process will consist of documenting that your state licensure is current and paying, via credit card, the $1120 recertification fee. You will also be able to schedule your examination place, date and time using a toll-free telephone number, or you may use the Prometric web site (www.prometric.com) to reserve a place, date, and time much as you would when purchasing an airplane ticket on the Internet.

The examination will be given in Prometric Testing Centers (formerly Sylvan Learning Centers) and Prometric will take responsibility for making sure the examination is "secure." There are over 400 such centers in the US and Canada. The generalist's exam will be offered nine months out of the year (April through December). The closed-book secure examination will consist of approximately 200 multiple choice questions and applicants will have 4.5 hours to complete the test (including a tutorial). If an individual fails the exam, he/she will be able to retake the examination for $195.00. There is no limit to the number of times an individual may take the examination.

Subspecialists who also wish to maintain certification in general pediatrics will need to take the generalist's examination. If subspecialists choose to remain certified only in their subspecialty, they will only be required to take the examination for their subspecialty. Those holding more than one ABP certificate, who wish to take more than one recertifying examination, may pay for an additional recertification examination at two-thirds the relevant fee. Many of the Parts 2 and 4 activities will overlap for specialists wishing to maintain generalist certification, thus reducing the burden of maintaining multiple certificates.

Most pediatricians admit the new format is more comprehensive and more likely to engender the trust of the public; however, they feel uneasy about the closed-book secure examination format for Part 3. Pediatricians complain that the closed-book situation does not measure the busy pediatrician's ability to answer questions by contacting colleagues, accessing reference publications, or going on-line. The AAP has expressed its concerns about Part 3 to the ABP. The ABP, however, feels strongly that it maintain this format for a number of reasons: it has evidence that other medical specialties are developing this type of recertifying examination; the American Board of Medical Specialties, which is the umbrella organization for 24 national medical specialty boards, is considering a resolution that all recertification examinations must be administered in a secure format; and, some state licensing agencies are likely to require a secure examination as part of a maintenance of state licensure if recertification is used to fulfill a requirement of license renewal. Prometric Testing Centers do not permit an open-book format for the examination because they administer multiple different examinations on the same day and no other organizations (eg, National Board of Medical Examiners) allow the open-book format.

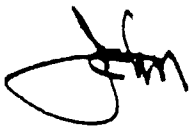
The AAP, while not responsible for certifying or recertifying pediatricians, does have a strong commitment to meeting the educational needs of the practitioner (including education for preparation for renewal of certification). Therefore, the AAP will continue to work closely with the ABP to ensure AAP professional education activities assist pediatricians in meeting all of the maintenance of certification requirements. The AAP has never excluded a Fellow from the organization because the Fellow failed to recertify. Please feel free to communicate your concerns about recertification to me as I represent you on the Board of Directors of the AAP.

I wish to thank Hazen Ham, Ph.D., Director of Recertification Programs for the American Board of Pediatrics, and Errol Alden, M.D., F.A.A.P., Deputy Executive Director of the American Academy of Pediatrics, for helping me write this commentary.

President's Message...continued from page 1

eligibility. Children with special needs are particularly vulnerable. Children's healthcare coverage cannot become a cynical, empty promise to our posterity.

We recognize that the challenges faced by State government are formidable and that time, energy, and resources are finite. We appreciate the attention that was given by all of the candidates to our issues this year; however, the election is now over and the line of responsibility is clear. We will bring to the effort not only a compelling definition of the problems, but concrete, workable solutions, based on the experience and convictions of our group. Working together, as people of good will, vision, and energy, we can reach our common goal: quality healthcare for the children of Tennessee regardless of means.



Children in State Custody

The Tennessee Department of Children's Services (DCS) has requested assistance from TNAAP regarding issues related to EPSDT services for children in state custody. DCS acknowledges the difficulty that physicians have in obtaining historical information on children in state custody and the problems performing an EPSDT screen without this information. They are trying to improve their processes and want specific feedback about physician issues. They are asking pediatricians to contact the DCS Health Unit Nurses (listed below) as difficulties arise so they can better address problems in their respective areas. They also request that, in those cases where little or no information can be obtained, we go ahead and see the child and complete as much of the screen as is feasible.

Dept. of Children's Services
HEALTH CARE ADVOCACY STAFF LIST (as of October 3, 2002)

REGION	NURSE	PHONE
Davidson	Patricia Slade, RN, MSN, MBA	615-253-5127
East Tennessee	Scott Melton, BS, RN, CCM	865-425-4527
Hamilton	Chip Dantzler, RN	423-634-3493
Knox	Katressa Tipton, MSN, RN, CPNP	865-594-7101 - Ext. 18
Mid-Cumberland	Patsy Sanford, RN	615-333-5425
Northeast	Rebecca Reed, RN, BSN, ANP,CS	423-727-1052
Northwest	Phyllis Parker, RN	731-884-2633
Shelby	Gerald Brown, RN	901-578-4078
South Central	Lynn Pollard, MSN, RN, CPNP	931-375-2000
Southeast	Cheryl Brazelton, RN, BSN	423-493-5960
Southwest	Sara Webb, RN	731-426-0782
Upper Cumberland	Tanna Short, MSN, RN-C, FNP	931-646-3027
Central Office	David DeGrella Program Coordinator 615-532-2267 Fax -615-741-7322 Primary Areas: MCO, TennCare Eligibility, and data quality	Diana Yelton Program Coordinator 615-253-4703 Fax -615-741-7322 Primary Areas: BHO, DCS appeals, and custody prevention for noncustody children.

Fenner, Lentz, and Ring receive the AAP Outstanding Large Chapter Award, presented by Wyeth-Lederle reps Susan Lincoln and Mike Dugan, on either side of Lentz. The beautiful plaque was accompanied by a $2000 check also from Wyeth.

2003 Calendar

Jan 18, 2003	TNAAP Board Meeting* Nashville
Apr 11, 2003	TNAAP Board Meeting* Montg. Bell State Park
Apr 12-13, 2003	TNAAP Planning Retreat Montg. Bell State Park

** All Chapter members are invited to attend the Board meetings, but please let the Chapter office know at least 2 weeks in advance.*

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2002 National Early Hearing Detection and Intervention Meeting

Mark S. Gaylord, MD
865-544-9320; mgaylord@mc.utmck.edu

I was honored to represent the Tennessee AAP Chapter at the Early Hearing Detection and Intervention (EHDI) Meeting in Washington D.C. earlier this year. This valuable meeting was co-sponsored by the CDC, HRSA, All Kids Count, National Center for Hearing Assessment and Management, National Institute on Deafness and Other Communication Disorders, Department of Education, and the AAP. The purpose of the meeting was to continue the goal of providing universal hearing screening to all infants. The AAP has become a major partner in this endeavor and sponsored a contact person from each state to attend. I will continue to serve as the Chapter's EHDI representative.

Congenital hearing loss affects 2-3/1000 infants in Tennessee and the United States. Hearing loss occurs more frequently than other screened newborn conditions (0.1/1000 births have PKU; 0.25/1000 births have hypothyroidism, 0.20/1000 births have sickle cell, 2.3/1000 have hearing loss). Infants with undetected or untreated hearing loss will not develop language and communication skills at age appropriate levels. The average age of identification of a deaf child is 14-22 months. Since any degree of hearing loss can affect language and school performance and birth to age 3 years is the most critical learning age for language development, it is not unexpected that one third of children with hearing loss in just one ear had to repeat a grade in school, and the average twelfth grade deaf child reads at a third to fourth grade level.

Technology is now available to reliably screen infants at birth (otoacoustic evoked emissions automated auditory brainstem responses). There is no "best" protocol, but several have been proven to work. Each screening center chooses the one that fits their situation best. Since 1994, there has been a large increase in infants screened (2001 > 2000 hospitals) with 67% of infants screened nationwide. Referral rates nationally are 2.2% (CDC data). We now screen about 75% statewide in Tennessee with reported referral rate of 0.9 to 2%. With these large numbers of infants screened, it truly has become "standard of care". The average cost for hospital-based screening is $26/infant; however, the cost of educating a hearing impaired child is $9,689 in regular classes to $35,780 in residential programs.

Studies have now shown that infants in treatment will develop near normal. Therefore, the goals of EDHI programs are to screen infants by 1 month, have a complete diagnosis by 3 months and intervention by 6 months. It is the AAP's desire that this process be integrated and linked with the pediatric medical home.

With grants from HRSA and CDC and the incorporation of newborn hearing screening in the 2003 EPDST Tennessee regulations, Tennessee hopes to exceed 90% screened. Plans are also in progress to link the reporting of referred newborn screens with the state metabolic screen form. The Department of Education, IDEA Part C Programs that include the Tennessee Early Intervention System (TEIS) and Tennessee Infant Parent Services (TIPS), will help with coordination of services for the referred infants. TEIS service coordinators work in each county in the state. The program has over 13 years of experience in working with children birth to 3 years old that may have hearing loss or developmental disabilities. TIPS school parent advisors also work in each county of the state. This program has over 35 years experience working with families who have young children with hearing loss. These groups can assist with referrals to appropriate pediatric audiologists for definitive diagnosis and amplification and referral to early intervention specialists for other treatment, if necessary.

A large amount of research and work has occurred in the past 5 years for the diagnosis of congenital hearing loss. Outcome data now supports that early diagnosis and treatment can help avoid long-term social behavioral and educational developmental delays. In a short 7 years, the U.S. has gone from 19% of infants screened to 67%. We also have made great progress in Tennessee, but we still have at least 25% of children not being screened. The AAP is asking all pediatricians to "champion" the goal of screening all children by one month of age and include diagnosed children in their medical home. We truly have a lot of work left to do.

Please help us screen all children in your community. Also feel free to contact me about this important issue.

References: 1) American Academy of Pediatrics Task Force on Newborn and Infant Hearing, Newborn and Infant Hearing Loss: Detection and Intervention. Pediatrics. 1999b; 103:577-530. 2) American Academy of Pediatrics, Ad Hoc task Force on Definition of the Medical Home. The Medical Home. Pediatrics. 1998; 90:774. 3) Joint Committee on Infant Hearing Position Statement. Principles and guidelines for early hearing detection and intervention programs. Pediatrics. 2000; 106:798-817. 4) Moeller MP. Early intervention and language development in children who are deaf and hard of hearing. Pediatrics. 2000; 106:e43. 5) Yoshinago-Itano C., Sedey A.C., Coulter RA, Mehl AL. Languages of early and later-identified children with hearing loss. Pediatrics. 1990; 102:1168-1171. 6) Yoshinago-Itano C. Universal newborn hearing screening assessment and intervention systems. Hearing Journal. 1999; 5216: 10,12,14,16,19, 20-21.

Great Web Sites

1. www.babyhearing.org
   Boys Town National Research Hospital
2. www.infanthearing.org
   National Center for Hearing Assessment

Tennessee Resources

1. Jacque Cundall, Tennessee Department of Health
   615-741-310 jcundall@mail.state.tn.us
2. TEIS 1-800-852-7157

TennCare Benefits

AMN = As medically necessary

Benefit	TennCare Coverage through 12/31/02	TennCare Medicaid Coverage 1/1/03	TennCare Standard Coverage 1/1/03
Inpatient hospital services	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN, with rehabilitation hospital services covered only as a cost-effective alternative
Outpatient hospital services	AMN	AMN	AMN
Physician inpatient services	AMN	AMN	AMN
Physician out-patient services	AMN	AMN	AMN
Physical exams and check-ups	Covered	Covered for children through EPSDT; covered for adults according to TennCare schedule	Covered according to TennCare schedule (AAP guidelines for children)
Lab/X-ray services	AMN	AMN	AMN
Hospice care	AMN	AMN	AMN
Dental services	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth [Additional dental package of services for children will be available for family purchase]
Vision services	Preventive, diagnostic and treatment services for enrollees under age 21; first pair of cataract glasses or contact lens/lenses following cataract surgery for adults	Preventive, diagnostic and treatment services for enrollees under age 21; routine eye care not covered for adults	Annual eye exam covered for enrollees under age 21; other routine eye care not covered for children or adults
Home health services	AMN	AMN, with a limit of 125 visits per enrollee per year for enrollees age 21 and older	AMN, with a limit of 125 visits per enrollee per year
Pharmacy	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)
Durable medical equipment	AMN	AMN	AMN
Medical supplies	AMN	AMN	AMN
Emergency ambulance transportation	AMN	AMN	AMN
Non-emergency transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation
Renal dialysis services	AMN	AMN	AMN

TennCare Benefits...continued

AMN = As medically necessary

Benefit	TennCare Coverage through 12/31/02	TennCare Medicaid Coverage 1/1/03	TennCare Standard Coverage 1/1/03
EPSDT services	Screening, diagnostic and follow-up treatment services AMN	Screening, diagnostic and follow-up treatment services AMN	Not covered
Chiropractic services	AMN for children through EPSDT; covered for adults as a cost-effective alternative	AMN for children through EPSDT; covered for adults as a cost-effective alternative	Not covered
Private duty nursing	AMN	AMN for children through EPSDT; not covered for adults	Not covered
Speech therapy	AMN for children through EPSDT; covered AMN for adults when provided by a licensed speech therapist to restore speech after a loss or impairment	AMN for children through EPSDT; for adults, limited to 60 days period from the date therapy begins for any one condition	Covered as short-term benefit per condition, limited to 60 days from original treatment
Occupational therapy		AMN for children through EPSDT; for adults, limited to 60 days period from the date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Physical therapy		AMN for children through EPSDT; for adults, limited to 60 days period from date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Organ transplant and donor organ procurement	AMN; for adults, transplant must be non-experimental	AMN for children through EPSDT; for adults, limited to coverage of transplants also covered by Medicare	Limited to coverage of transplants also covered by Medicare for beneficiaries who have been enrolled in TennCare for a period of 6 months
Sitter services	AMN	Not covered	Not covered
Convalescent care	AMN	Not covered	Not covered
Reconstructive breast surgery	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	Covered in accordance with Tennessee Public Chapter 452
Psychiatric inpatient facility services	AMN	AMN	AMN
Physician psychiatric inpatient services	AMN	AMN	AMN
Outpatient mental health services	AMN	AMN	AMN
Inpatient and outpatient substance abuse treatment services	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and $30,000 in lifetime benefits	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and $30,000 in lifetime benefits	AMN limited to 10 days detox and $30,000 in lifetime benefits
Mental health case management		AMN	AMN
24-hour residential treatment	AMN	AMN	AMN
Mental health crisis services	AMN	AMN	AMN

Cola Wars

Tennessee Society of Pediatric Dentistry
(Compiled by Ed Perdue, DDS, Hendersonville
615-824-1700)

Americans consume soft drinks at an alarming rate. During the time period from 1978 to 1994, soft drink consumption by U.S. teens tripled. By 1998, Americans were consuming 15 billion gallons of soft drinks, equivalent to 558 12oz cans per person per year. The National Soft Drink Association reports that one out of every four beverages consumed in America is a soft drink. This averages to 56 gallons per year for every person in the United States. Consumption among males 12-19 years of age can be as high as 81 gallons per year.

The consumption of highly sugared, acidic, caffeinated, carbonated beverages contributes to the rapid onset and progression of dental caries in children and adolescents. The habit forming potential of the caffeine in these beverages only increases the concerns about dental disease and the overall health of children and adolescents.

According to the Center for Sciences in the Public Interest, twenty percent of one and two year old U.S. children drink soft drinks, with an average consumption of seven ounces per day, containing over 50mg of caffeine. There is concern that the pattern for caffeine ingestion begins at a very early age, as its use in medications, soft drinks, and other foods for children is common and accepted. Regular caffeine ingestion may lead to habitual usage.

The increase in cola consumption combined with an apparent decrease in the consumption of milk not only increases the risk of dental caries in children and teens, but may contribute to a wide range of other health problems, including a decrease in bone density and a subsequent increase in fractures.

National marketing and advertising campaigns for many products, especially colas, have aggressively targeted the child and teen markets. The American Dental Association has expressed concern about "pouring rights contracts" which give soft drink companies exclusive rights to place vending machines in schools in exchange for large monetary contributions.

Caffeinated carbonated beverage consumption poses significant risk to the overall heath to children in America. Education is the key to helping families make informed choices about the products they purchase and consume.

Annual Board Planning Retreat May 2002 Fall Creek Falls State Park

Above: Immediate Past President Joe Lentz, MD, with wife Betty.

AAP President Steve Edwards, MD, enjoys the beauty of Tennessee.

Below: (r-l) Mick Connors, MD, Bob Lembersky, MD, Ovidio Bermudez, MD, and Pat Strauss with members of the Lembersky family.

Volunteer leaders work to set the course of TNAAP's future.

Local Pediatric Society Updates

Davidson County Pediatric Association (DCPA)

Beverly Frank, MD, President
bevfrank@comcast.net
615-851-7865

Davidson County's Overall Dinner

DCPA had two meetings earlier this year. In late March, we met with Dr. Pedro Garcia, Nashville Metro's school superintendent. He presented his plans for increasing reading and math scores in the school system as well as his philosophy of educating children. He encouraged us to emphasize to all our parents how important it is to read with their children on a daily basis. This could be done at every physical exam, starting with infants. He also feels that this practice should continue through middle school, always reading to your children at a level higher than theirs so they are pushed to learn new vocabulary and discuss ideas with you. In May, DCPA and Vanderbilt co-hosted the annual dinner that is in memory of Dr. Overall. The speaker this year, Dr. George Lister from Yale University, discussed what he has learned over the years from his mistakes.

Hamilton County Pediatric Society

Tomasz Voychehovski, MD, President
423-855-0841
tomekvoy@cs.com

Hamilton County's "Picnozium"

The Hamilton County Pediatric Society (which includes Chattanooga and the surrounding area of southeast Tennessee) had its first Pediatric Picnic (tagged by some as the "Picnozium") at the scenic Harrison Bay State Park in April. The Society was generously supported by the companies of Daiichi, McNeil, Lederle, Ross, and Sepracor. With the fantastic spring weather, pediatricians and their families enjoyed camaraderie, food, tennis, hiking, and stories by actress/story-teller Colleen Laliberte. The Society committed its new projects to the following:

(1) promoting breastfeeding and prenatal visits in alliance with ob-gyn and family practice doctors, and

(2) the cooperation between librarians and pediatricians to promote reading.

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THE OFFICIAL PUBLICATION OF THE TENNESSEE CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY

SPRING 2002

CMS, VACCINES and the PEDIATRICIAN

Joel F. Bradley, MD, FAAP,
CPT Coding Advisor
(w) 615-936-6053

Immunizations are part of what we do, and changes in the Medicare fee schedule for 2002 threaten to change our ability to keep our kids protected against disease. Developing a strategy to deal with this in your practice requires the information summarized below.

The problem- As you may recall about three years ago, billing for vaccines changed at the request of the CDC to create separate CPT codes for vaccine products and their administration. New codes for vaccine administration were developed, and in their present form allow one to bill for the first vaccine administered (90471) and subsequent vaccines (90472 for each). For a typical two month old, if one gives 4 vaccines, we submit a CPT code for each vaccine product, 90471 (once) and 90472 (three times). With over twenty vaccines given during childhood and more to come, a little change in the reimbursement fee can produce a great change in the practice's bottom line at year's end.

CMS (formerly HCFA, now the Centers for Medicare and Medicaid Services) has published for the first time this year the relative values for 90471-2- but *without* the physician work value that was well demonstrated by our AAP surveys and recommended by the AMA RUC (relative value update committee) to CMS. As you can see from the table below, this omission lowered the total relative value by about 60%, and considering the CMS-imposed 5% decrease in the 2002 conversion factor, the reimbursement totaled $3.98. CMS equates the code to the antibiotic administration code 99078.

continued on page 4...

District IV Chair Commentary:

Coparent or Second-Parent Adoption by Same-Sex Parents

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dtayloe@aap.org

Board members of the AAP have been besieged by angry AAP Fellows and lay citizens since the publication of the Policy Statement and Technical Report on the topic of Coparent or Second-Parent Adoption by Same-Sex Parents in the February issue of Pediatrics. The Committee on Psychosocial Aspects of Child and Family Health (COPACFH) wrote these documents, multiple groups within the AAP reviewed them, and all ten members of the Board of Directors approved them. The process of developing the Intent for Statement/Technical Report and completing the work leading to publication in Pediatrics took about three years.

I came on the Board in late October of 2001, and these documents were approved before my official duties on the Board began. When I learned of the documents after the first critical media blast, I read and studied both documents and became involved in Board-level discussions, as well as discussions with AAP Fellows and lay citizens. I believe the Committee attempted to carve out a very unusual situation and address the needs of the at-risk child who finds himself/herself

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INSIDE

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Next Issue: Summer 2002
Deadline for entries: May 10, 2002

NEWSLETTER EDITORS
Catherine M. Fenner
Joseph F. Lentz, M.D.

President's Report

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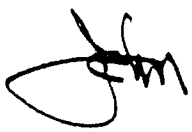
I am back at my childhood home, and it is real winter here. My wife Adriana and I are driving up the North Shore of Lake Superior to Bearskin Lodge, an old bass fishing camp in the Arrowhead Country of Northeastern Minnesota, where the wilderness blurs off into Canada. The rental car is warm, and I've managed to retain some skills for driving on ice and snow. Public radio's pledge week programming is dominated by the fight that state legislators are making to return their income tax rebates to Governor Ventura and apply them, instead, to support of the public schools. Amazed, we turn the radio off and listen to zydeco music on the disc player. For the fifteenth year in a row, we are joining the same group of friends for a long weekend of cross-country skiing, fellowship, and good food. Bearskin is beautiful, pristine and remote; contact with the world is limited to French-language hockey games on the radio and to a single, communal telephone. It is a place that lends itself to reflection, as does this time of life for me.

Curiously, my thoughts turn to the Chapter and not just because this report is due upon my return. Direct patient care remains a rewarding, sometimes still an exhilarating, experience for me, but I increasingly feel the need to reach beyond these very personal encounters in hope of impacting children's lives more broadly. Unabashedly, I have come to recognize that what is good for pediatricians is good for children, too. The Chapter provides the ideal venue for this type of action, one in which we can work together to improve children's healthcare at both the State and the National level. The Tennessee Chapter has an important perspective to share with the National organization. Consider our practical experience with universal health insurance coverage for children; as pediatricians, we share a common goal with our colleagues in other parts of the country but, as we have learned to our dismay, "the devil is in the details". Similarly, we recognize the importance of clearly identifying and thoroughly discussing our social agenda as we make policy. Closer to home, it is my hope and intention that new Chapter initiatives, e.g. the EPSDT contract already in place and the developing task forces on HIPAA regulations and Synergis reimbursement, will provide real value to our members. Your Chapter leadership is working to re-invigorate our committee system, modifying its structure to more completely engage the talents of our members and bring them to bear efficiently on issues of substance.

Nothing will come to us for free. Our busy professional and personal lives necessitate that we apply a healthy skepticism to any demands made upon our time and energy. It will require the courage of our convictions to advocate for tax reform, recognizing that, regardless of the cost, we must take control of the process in support of education and healthcare. I am confidant that we will make the effort and that our effort will be successful. I am truly grateful for the opportunity to work with you over the next two years. It is good to be at home in Tennessee.



Legislative Advocacy

Catherine M. Fenner, Executive Director

Executive Director's Report
Catherine M. Fenner

Just prior to the reconvening of the 102nd Tennessee General Assembly, Vanderbilt's pediatric residency program held an Advocacy Week in January. Organized by Chief Resident Dr. Jason Kastner (some of you may remember Jason as one of my legislative interns last year), we spent three lunch hours during the course of a week discussing various types of advocacy. The first day I presented the basics of legislative advocacy. The second day, our Chair of the Committee on Children with Special Needs, Dr. Quentin Humberd from Clarksville, spoke about community advocacy and specifically the Medical Home project he has been working on with Family Voices. Our Program Director, Patrice Mayo-Ligon, also used our recent bicycle helmet campaign as an example of a Chapter member (Dr. Mick Connors) making his interest in injury prevention and a bright idea come to fruition. We wrapped up the week with a concrete example of legislative advocacy by having Representative Gene Caldwell, Representative Kim McMillan, and Dr. Ellen Wright Clayton discuss last year's passage of the bill that granted absolute immunity to pediatricians when reporting suspected child abuse. Dr. Clayton was instrumental in the passage of that bill by spending countless hours on the Hill explaining to the legislators the real-life situation faced by pediatricians. Rep. McMillan, who sponsored the bill in the House, received the 2001 Legislator of the Year Award for her efforts.

During the first active month of session (February), I was blessed again to have two wonderful third-year pediatric residents commit their month of advocacy to learning the ropes on the Hill; this brings the number of residents trained through this arrangement with Vanderbilt to eight. Dr. Alison Asaro and Dr. Buddy Creech were constantly researching and reading bills, identifying bills of interest and sitting through hours of committee discussions. As often happens, their medical expertise was particularly helpful when we were approached by many sides regarding a bill to allow glucagon administration in schools and another mandating schools to report the number of children taking medications in schools for ADHD. (See article on back page.)

Meanwhile, we have quietly held at bay the annual bill to grant prescribing authority of psychotropic drugs to pyschologists, the other annual nightmare to lift the ban of firearms on playgrounds and school property, and a bill which would require all children entering any pre-K or Head Start program to have a vision screening performed exclusively by an optometrist or ophthalmologist. As the Committees are working to close down so they can turn their attention to the budget crisis, these bills should be gone-- for this year, anyway. We continue to forge new alliances with other lobbying groups on the Hill, which has been extremely helpful in defeating these bills.

Dr. Quentin Humberd discusses community advocacy and his Medical Home project with Vanderbilt pediatric residents during January's Advocacy Week.

In addition to the optometrists' and psychologists' bills mentioned above, scope of practice bills are abundant this year. The Tennessee Medical Association (TMA) continues to address legislation that expands the scope of practices of "advanced practice nurses", chiropractors, orthopaedic PAs, and podiatrists.

Of course, the budget remains an enigma for most legislators, and they do not seem to understand that already the needs of children in this state are not being met, and to make more cuts will only do more harm. I encourage each of you to voice your personal opinions on tax reform to your own state senator and state representative. And please, get involved in an election this year, whether it be the gubernatorial race, the U.S. Senate race, the 4th, 5th, or 7th Congressional races, or your state senator or state rep race. Your time, as well as your dollars, do not go unnoticed and can make a lasting impression.

Rep. Kim McMillan (center), along with Dr. Ellen Clayton and Rep. Gene Caldwell, explain the importance of legislative advocacy during Vanderbilt's Advocacy Week in January.

...CMS, Vaccines, continued from page 1

Code	Proposed work rvu run by AAP-AMA	Total published work rvu - CMS	Total reimbursement AAP-AMA	Total reimbursement CMS 2002
90471	0.17	0	$10.14	$3.98
90472	0.15	0	$9.41	$3.98

CMS maintains that physicians do not spend time counseling patients about the vaccines (informed consent). While this may be true to some extent for the adult influenza and pneumonia vaccine (often given outside the practice setting such as a drugstore), it is not reflective of our practice as pediatricians. In fact, the work is increasing as many well-publicized (Rotavirus vaccine, intestinal obstruction) and unsubstantiated adverse affects (MMR-autism) appear. To make matters worse, CMS did not consider the well-demonstrated additional nurse time in giving vaccines versus another type of injection (documentation) and cost of materials like the Vaccine Information Sheets (VIS) we must furnish to each patient in an appropriate language.

Practice Impact- Since the values were never published until this year, all insurance companies and state Medicaid programs had to arrive at a reimbursement value without using the fee schedule. Surveys show values ranging from three to eighteen dollars, with an average of about $10 nationwide. If a pediatrician has 100 newborns a year, then on average the loss would be about $12,000 per year if those payers adopted the Medicare numbers (about two thirds of private payers or state Medicaid plans use the RBRVS).

The Solution- At the practice level, make sure you do not contract for the 2002 RBRVS fee schedule! Why not? First, it contains the low relative values for vaccine administration, and secondly the lower conversion factor for 2002 drops the payment for all codes by over 5%. Stay with the 2001 schedule and the 2001 conversion factor. Next, start checking your remittances from payers and see where they are headed. A call to the plan's medical director may help educate them and create a quality concern for the plan. The changes to the fee schedule codes and the conversion factor may apply to the state of affairs in the Medicare world, but neither change should apply to service to children or any non-Medicare patient and service.

At the state level, report to TNAAP any payers who are using the new values so the Chapter can both monitor the size of the problem and lobby on your behalf to repeal the changes. State Medicaid officials have been apprised of the potential impact this would have on both immunization rates as well as EPSDT screening rates if physicians were unable to afford giving vaccines in the office.

On a national level, write or call your U.S. Senators and Representatives-- there is even a form letter preprinted on the AAP website that can be modified for your practice and your concerns. Meanwhile, the AAP continues to work with CMS for a remedy.

(For another discussion of the subject, see February AAP NEWS, Washington Report. If you need a basic refresher on the Medicare Fee Schedule, look for the new 2002 RBRVS brochure on the AAP website.).

Welcome New Members

Paul G. Barongan, MD	Oak Ridge
E. Heather Fairbank, MD	Nashville
Jodi Burton Gage, MD	Johnson City
Robert Higginbotham, MD	Memphis
Wendy L. Hitch, MD	Hermitage
Kasey A. Huff, MD	Collierville
Carle Crane Kalsi, MD	Memphis
Rebecca Ruby Powers, MD	Johnson City
John Proctor, MD	Nashville
George William Robertson, MD	Lebanon
Katherine Tun, MD	Chattanooga

Please Welcome Your New and Newly Elected Board Members

John C. Ring, MD, President (Memphis)
David K. Kalwinsky, MD, Vice-President (Johnson City)
J. Michael Connors, MD, Secretary-Treasurer (Knoxville)
Martin I Herman, MD, Fellow At-Large, West TN (Memphis)
Patricia C. Davis, MD, Fellow At-Large, Middle TN (Columbia)
Charles L. Campbell, MD, Fellow At-Large, East TN (Oak Ridge)
Robert B. Lembersky, MD, Program Chair (Knoxville)
Mary E. Keown, MD, Membership Chair (Nashville)
Elizabeth M. Andrew, MD, Nominating Chair (Memphis)
Tomasz H. Voychehovski, MD, Pres., Hamilton County Pediatric Society (Chattanooga)
Patrice Reed, MD, Pres., Memphis Pediatric Society (Memphis)

Membership Dues

Invoices for your FY03 dues will be sent to you in May from the AAP, which we contract with as our dues billing service. Those dues will cover the period of July 1, 2002 through June 30, 2003. Please note that while both national and state chapter dues are on the same invoice, you are not obligated to be a member of both. However, we sincerely hope that the significant growth and accomplishments of your TN Chapter over the past year will warrant your renewal to your state Chapter in addition to your national membership.

Thank you!

UPCOMING WORKSHOPS

"Assessment of the Pediatric Patient"
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District IV Chair Commentary
...continued from page 1

in the predicament of being the biological child of a gay/lesbian custodial parent. These children do not have access to a traditional family unit, and we pediatricians must help them make the best of a difficult situation. The AAP cannot, as a public policy organization, say that a given adult is unfit to be a parent simply based on the sexual orientation of that adult. We all have learned that all children need as many responsible adults in their lives as possible. Most adoption procedures require the adopting adult to prove that he/she is really worthy of being made a legal parent/guardian of the child. The AAP was simply trying to say that gay/lesbian partners of gay/lesbian biological parents should have the right to adopt the children of those biological parents. If I had been asked to approve the documents in question, I would have approved them. However, I think the AAP Fellows who have complained to me about the documents have made one point absolutely clear: that the AAP has spent an enormous amount of time and energy on a "fringe issue" as it relates to the American family. The AAP has failed to do anything substantial to publicly promote the value of the traditional family unit for the average child. It will be my task, as your representative on the Board of Directors of the AAP, to focus the Board on addressing the fact that the American family is in crisis and that pediatricians are in positions to improve the health of children by increasing the number of children who grow up in traditional family units.

When I became Vice President of the NC Chapter of the AAP in 1990, and attended my first Annual Chapter Forum (annual meeting of the AAP leadership), I recall a resolution that asked the AAP to study the growing numbers of single-parent families in America, and further asked the AAP to promote the value of the traditional family unit to the average child. The AAP leadership, which included all the chapter vice presidents and presidents, could not pass this resolution because it appeared to say that single parents were bad parents. District IV continued to rewrite this resolution until it finally passed, several years later, and was referred to the AAP leadership for further action. When Joe Zanga, then of District IV, became President of the AAP, Joe appointed a Task Force on the Family to study family issues and develop a report for the Board of Directors. Joe appointed the original author of the single parent resolution to the Task Force.

The Report of the Task Force, in draft form, arrived on my desk during the furor that erupted after publication of the Coparent Adoption documents. This report is loaded with data to support the value of the traditional family unit to the average American child. This report is on the agenda of the Board of Directors for the upcoming May meeting. It is my hope that the AAP leadership can utilize this report to tell the public and the membership what we already sense is happening to families in America, and the devastating effects these changes are having on our children. I firmly believe that children deserve to be born into a loving family that consists of two legally married heterosexual adults who are committed to stay together "for better or worse" so that their children will have the best chance to grow up to be responsible, productive adult citizens. I fully understand that there are aberrations galore of the traditional family unit and that we all must scramble every day to help those at-risk children do the best they can in these difficult family situations, such as the gay/lesbian dilemma that started this discussion. However, the AAP must help us and the public focus on what is really best for children in these very difficult times, and I sense that our membership feels a bit betrayed by the AAP when it comes to family issues. I think we can all do better. I welcome your advice on this and any other child health issues.

EPSDT Contract with TennCare Continues

Ruth E. Allen, EPSDT Coordinator

Ruth E. Allen, EPSDT Program Director
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We were successful in renewing our Early Periodic Screening, Diagnosis and Treatment (EPSDT) contract with TennCare through June 30, 2002 and hope to obtain a 12-month contract for the fiscal year beginning July 1, 2002.

We are continuing to meet with state officials to share pediatricians' concerns about TennCare and to improve access to care for children in Tennessee. As we work with the state to improve EPSDT screening rates, one of the key focuses of our activities during the first quarter of 2002 is to obtain data from the state. We are working with the state to obtain information such as:

- ✔ network deficiencies by specialty type and geographic location;
- ✔ average TennCare reimbursement by CPT code, (we hope to obtain in order to compare to the AAP's South Central Average as published in the Medicaid Reimbursement Survey, 2001);
- ✔ results from the state's audits of primary care physician offices on the completeness of documentation regarding the seven components of EPSDT screens (see article on page 10); and
- ✔ the percentage of children who are receiving screens by age group and by geographical location.

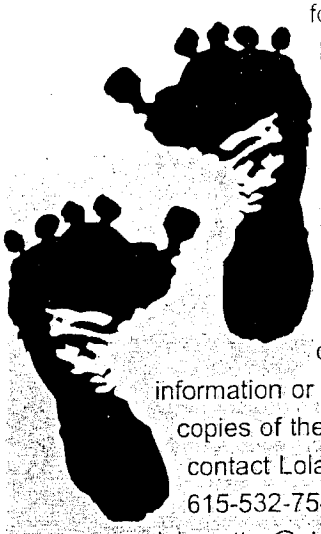
Other key activities this quarter have included:

- ✔ We have established an EPSDT forms committee (chaired by Iris Snider, MD) to maintain the age-specific EPSDT documentation forms to be used in pediatric offices (these forms have been well-received by the majority of our members).
- ✔ I had the opportunity to visit my Medicaid counterpart at the Georgia AAP Chapter to observe and share successes and challenges.
- ✔ I have continued to represent TNAAP in various state meetings including the EPSDT work group (with MCO representation), meetings with the Children's Health Initiative, providing input regarding the EPSDT public awareness campaign, etc.
- ✔ We have established a contact person to address issues as they arise with local health departments providing EPSDT services. (See article on page 9.)
- ✔ I am working with various agencies to obtain information on best practices across the country for outreach to parents to get their children in to their doctor's office to obtain preventive health screenings.
- ✔ I have participated in various HIPAA trainings, and we have begun compiling resources to aid members in becoming HIPAA compliant.
- ✔ We continue to stress the importance of eliminating "hassle factors" in TennCare (for example, we are still working on the issue of a common referral form). We are also helping the state understand barriers to making behavioral health referrals.

How can I help you? Do you have issues in your office that relate to EPSDT? Do you or your staff need additional training about the EPSDT services or documentation requirements? Are you having billing problems with certain MCOs for EPSDT services? Please contact me if I may be of assistance.

EPSDT Public Awareness Campaign

As part of the state's initiative to increase EPSDT screens, they have launched a public awareness campaign called "Tennessee Caring for Kids". You should have received a letter from TNAAP in February notifying you about this campaign and providing you with copies of the informational poster and brochures. If you did not receive this information or if you need additional copies of the materials, please contact Lola Potter at TennCare at 615-532-7542 or lola.potter@state.tn.us.



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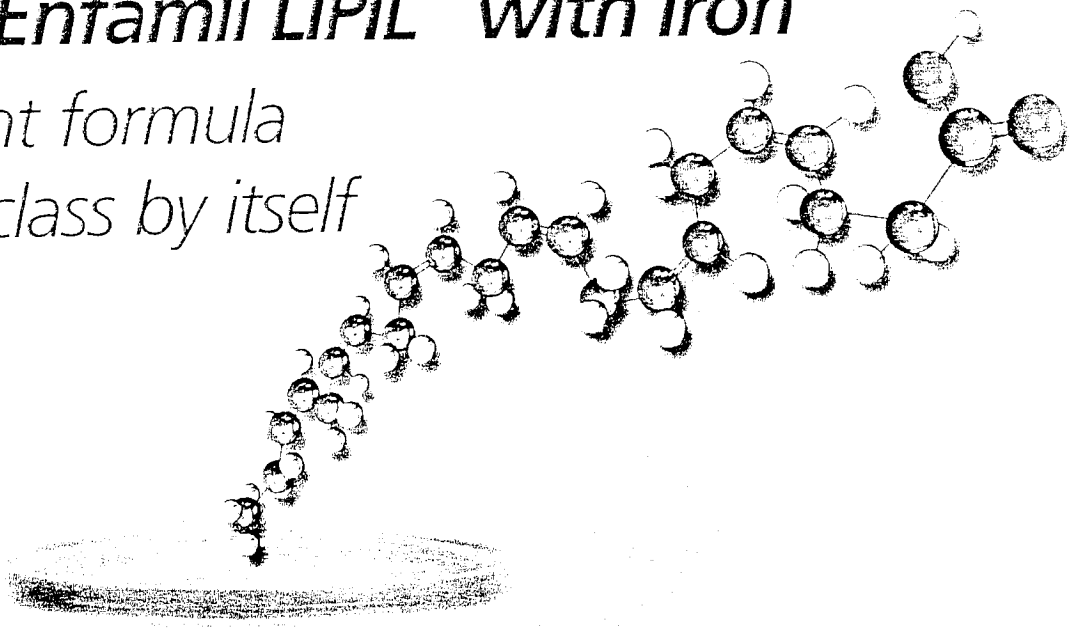

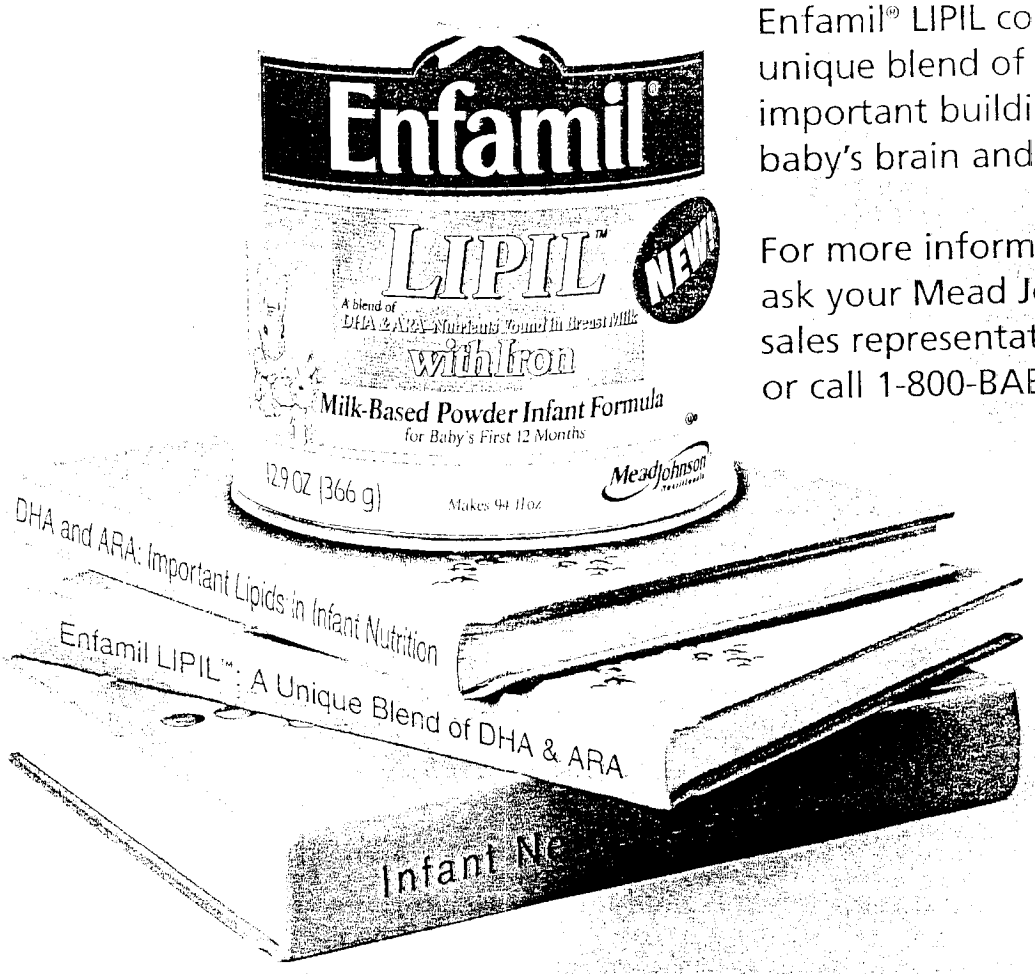

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References: 1. Birch EE, Hoffman DR, Uauy R, et al. Visual acuity and the essentiality of docosahexaenoic acid and arachidonic acid in the diet of term infants. *Pediatr Res*. 1998;44:201-209. **2.** Birch EE, Garfield S, Hoffman DR, et al. A randomized controlled trial of early dietary supply of long-chain polyunsaturated fatty acids and mental development in term infants. *Dev Med Child Neurol*. 2000;42:174-181.

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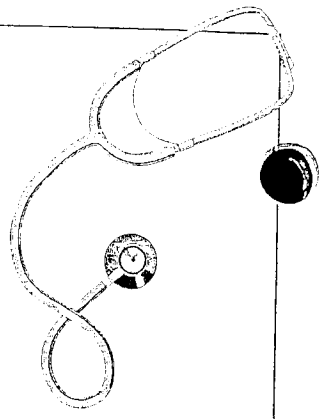
Coding For Preventive Medicine and EPSDT Visits

Joel F. Bradley, MD, FAAP, CPT Coding Advisor
(w) 615-936-6053



As you know, the Chapter is working with the state to improve the EPSDT program, both at the practice level with the visit itself, and at the MCO level looking at reimbursements. One should learn the following information about coding to bill and contract for the service provided in the office.

Most EPSDT visits are performed as preventive medicine visits (CPT codes 99381-99395), although the state for counting purposes uses newborn visits in the hospital as well as obstetric visits. There are three basic points to learn, two of which affect the way you bill. MCO variation is common, and we are working with the state and MCOs to help reduce these payment policy discrepancies.

1) SCREENING SERVICES- According to CPT rules, when one does a well visit and provides screening or procedural services in addition to the well visit, they are separately billable if they have their own CPT code (this is explicitly stated in the CPT book). Such services would include formal vision screening (99173), hearing screening using an audiometer (92551), and developmental behavioral screening when a formal exam is used (96110). In addition, the vaccine administration codes and the vaccine codes, plus any labs are also billed separately. The table below lists the codes available to completely bill for the service.

Following the EPSDT guidelines (which parallel those of the AAP), these codes are used when formal objective tests are used, not simply when one takes the history of the child's ability to hear or see (as is done in the infant before office testing is usually possible). For hearing screens, most offices use an audiometer and can bill the code in addition to the well visit, and it is usually paid. The vision code, 99173, is a relatively new code, is published in the RBRVS without values, and is often not reimbursed. However, those who screen three and four year olds (we all should, according to the guidelines), understand the substantial effort and time required and subsequently the need for additional reimbursement. Similarly, a relatively new code exists for limited developmental tests- examples given in CPT for this code include the DDST2 and the ELMS (Early Language Milestone Screen). Most of the tests recommended in the EPSDT guidelines fit this description.

The Problem: Many payers have considered some of the payment for screens to be bundled into their payment for the well visit – especially vision and hearing. The AAP surveys members each year to collect payment data; more and more payers are covering these codes each year. In Tennessee, some of the MCOs correctly allow billing/payment for all these codes, some pay only for one or two of the screening tests (usually hearing), and some do not pay separately for any.

The Solution: At the practice level, providers should survey their payers, especially the TennCare MCOs, and if these are not covered, make the case for payment when they file claims, work denials, and contract with services. At the state level, the Chapter is working as above to help decrease variation, and we will keep you posted of progress.

2) MODIFIER 25- Correctly coded, one can bill both a well visit and a separate illness/problem dealt with at the same visit by attaching the modifier 25 to an office visit code that fits the additional work done. Example: 6 year old with EPSDT which is completed, with 15 minutes additional time and additional history and medical decision-making done for asthma care. Here, one would correctly bill the well visit, 99393 linked to diagnosis code V20.2, and also bill a 99213-25 linked to the diagnosis code for asthma 493.00.

The Problem: Not all payers pay for both codes, and the ones that do not usually pick the cheaper one to pay. The good news is that most of the TennCare MCOs do pay for both, and the numbers of major carriers in the private sector who do are increasing each year since CMS recognized the code (AMA payer survey data).

The Solution: Check payer data or query your provider representative. Too many kids are sick or have a medical problem at the same time they come for a

continued on page 9...

Service	CPT Code
Well visit	99381-99385-new patient, by age 99391-99395- established, by age
Vision screen	99173
Hearing screen – screening audiogram	92551
Developmental screen	96110
Vaccine administration	90471 (first), 90472 (each subsequent)

...Coding continued from page 8

well visit to let this go unreimbursed if the majority of payers cover it. If yours does not, put this in the contract. Of course, if a separate problem takes little time or work (some diaper rashes, thrush), do not bill separately.

3) COMPREHENSIVE EXAM-
Comprehensive exam as described in CPT does not equal the Comprehensive exam one must do to bill for the highest level 99215 in the office. CPT states that the exam can be tailored by the provider to what is appropriate for the patient's age and sex. With input from several practices, the Chapter has developed well visit encounter forms which provide the age appropriate documentation in a checklist format, and if completed, will pass audit with both private and TennCare carriers. As you know, if the services we perform are not documented, they were not done as far as payers and malpractice attorneys are concerned.

Local Health Departments Now Providing EPSDT Screens

Annette Goodrum, RNCS, MCH Consultant, Tennessee Department of Health
615-741-0393

[Note: This article provides an overview of the history of why this development has occurred and how the process is expected to work. TNAAP has expressed concern about the potential negative impact this could have on the medical home concept. The health department has assured us that their intent is to enhance the medical home concept, to encourage parents to be in dialogue with the PCP and to help children with out a medical home get referred to a physician who can provide one. While there is controversy about how well this will work, TNAAP wants to encourage partnering with public health to increase screening and immunization rates in Tennessee. Our EPSDT Director, Ruth Allen, has a contact person with the department of health for any issues that arise. We expect this process to have different impacts across the state. If you have a lack of communication or other issues with your local health department as they begin providing EPSDT screens, please contact Ruth Allen, our EPSDT Director, at 865-927-3030.]

In 1998 the State of Tennessee entered into a Consent Decree in Federal Court in which the state agreed to make dramatic improvement in the EPSDT (well child) screening rates. In 2001, the state was back in court facing contempt charges, because the EPSDT screening rates had not improved as promised in the decree. Under the decree, screening rates are calculated by multiplying the number of screens reported to the state by the MCOs (through claims data) times the percentage completeness of screens based on TennCare audits (see separate article on audit results). For the federal fiscal year 2001, the Tennessee screening rate is: .45 (percentage of children receiving screens based on claims data) X .70 (the completeness rate) for a screening rate of .315 or 31.5%. The decree requires that the screening rate, by federal fiscal year 2002, be 80%

In an effort to reach the 80% target and avoid serious repercussions related to failure to comply with the Consent Decree, the state has undertaken a number of steps to improve the EPSDT screening rate. One of these steps involves requiring every MCO to contract with local health departments for EPSDT screening services. The Tennessee Department of Health has entered into an interdepartmental agreement with the Bureau of TennCare to provide outreach and screening services. As a result, local health departments are under a mandate from the Department of Health to do everything possible to encourage parents to get their children screened and to offer screening services to families with children enrolled in the TennCare program.

One way the local health departments are complying with this mandate is to offer EPSDT screening services to families whenever a child is in the health department for any kind of service (WIC, immunizations, etc.). If the parent expresses a desire to have their child screened but prefers to receive the service from their designated primary care provider (PCP), health department staff will offer to assist the family in making that appointment.

Whenever a parent does choose to have the health department provide an EPSDT screen, a form is then sent to the child's PCP to let him/her know that the screen was done and to notify him/her of any identified problem. If the child has a problem in need of immediate follow-up, health department staff will assist the family in making an appointment with the PCP or other provider recommended by the PCP.

EPSDT screens in health departments may be performed by physicians or nurse practitioners, however, the majority of screens will be performed by public health nurses. Prior to the initiation of TennCare, public health nurses were actively involved in the delivery of EPSDT services. As the local health departments across the state have prepared to become re-involved in the delivery of these services, local public health physicians and nurse practitioners statewide gave physical assessment updates to nurses previously trained in physical assessment. For nurses not previously involved in the delivery of EPSDT services, more extensive training has been provided.

TennCare Update

Iris G. Snider, MD, Chair, Committee on Child Health Finance
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As I have talked with pediatricians across the state in the past few days, I have been impressed by the huge disparity in satisfaction with the TennCare program at this point in time. Those of us in east Tennessee had no new MCOs in our region during the changeover last fall and had only a small penetration of Access MedPlus enrollees in most practices. We have concerns about poor subspecialty and mental health coverage, but few other complaints that encompass all providers. Alas, for pediatricians in middle and west Tennessee, things have not gone so smoothly during the past 6 months. Having BlueCare, and later, Access MedPlus patients reassigned while dealing with a new MCO in each region has created many problems. For pediatricians in middle and west Tennessee, their experiences are reminiscent of the early years of TennCare. As one pediatrician told me, "only an understanding banker is keeping us from bankruptcy". This was a common concern during the first year or so of TennCare but had receded until this year. The patients who were transferred from Access MedPlus to TennCare Select are expected to be transferred to existing MCOs as soon as the MCOs have capacity. None of these patients have been moved yet, and there is some question about the actual time frame for this due to lack of space in the other MCOs.

On a more positive note, the Chapter's contract to help with EPSDT issues and the recruiting of more pediatricians into TennCare was renewed for another 6 months. Pat Davis from Columbia continues as Medical Director with Ruth Allen as our EPSDT Director.

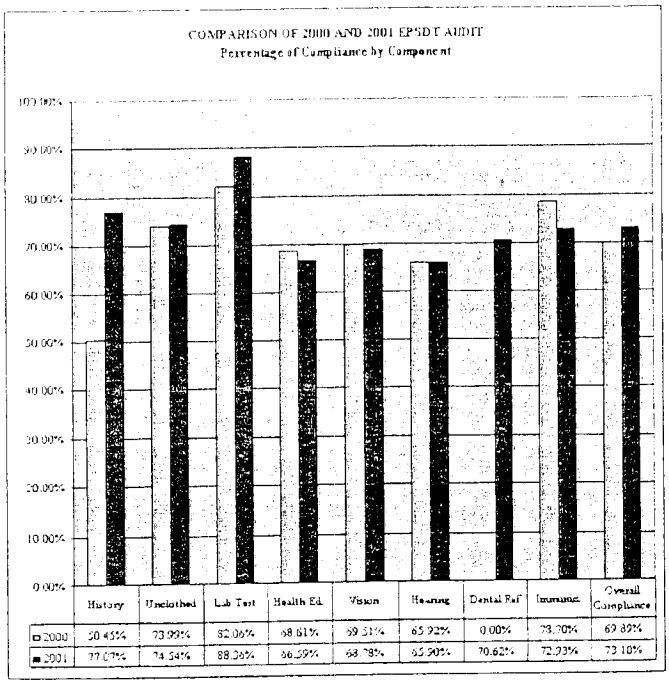
Finally, Mark Reynolds decided to reactivate the Medical Care Advisory Committee for TennCare. This committee was authorized for Medicaid by an administrative rule in 1981 but to my knowledge, has not been in place at anytime during TennCare. I was appointed to it as the representative of our Chapter and the first meeting was February 15th. This is a committee of 15 people with representatives from provider and advocacy groups. Our mission is to bring forward the problems we are seeing with TennCare and to try to find workable solutions. This is not the "Board of Directors" for TennCare that was proposed by the Commission on the Future of TennCare (which will be announced in June rather in than in January as originally stated).

I need help from all of you to be effective on this committee. I think that a review of all the agendas that we have taken to our meetings with the various heads of TennCare will show the continuing problems that need to be addressed. However, just as I was relatively unaware of the problems in middle and west TN with all the changes in MCOs, there are definite blind spots in my knowledge of what is happening to other pediatricians. SO, PLEASE KEEP ME INFORMED OF THE PROBLEMS YOU ARE SEEING AND THE SOLUTIONS YOU THINK WILL WORK. I have used the analogy of the blind men describing the elephant ever since I began to deal with TennCare, and that analogy holds more true than ever with the state now divided into regional MCOs. There is no reason to have a representative on this committee (or for me to spend my time as this representative), unless we can solve some of these problems by being on it. As always, I appreciate your help with this; please keep me informed of your problems with TennCare. I am hopeful we can use this committee for input about and solutions to the chronic problems of the past 8 years.

TennCare EPSDT Audit Results

TennCare conducted physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per physician site were audited (compared to 8 charts per physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).

TennCare conducted Physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per Physician site were audited (compared to 8 charts per Physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000)



Vaccine Shortage

Jerry Narramore,
Immunization Program Director, TN Dept of Health
615-532-8517

The national shortage of many of the routine childhood vaccines is expected to continue into at least the summer of 2002, with some vaccines being in short supply until the fall. The shortages, brought on by a combination of events, have placed many providers in the position of deferring doses and having patients in for multiple visits. There are now shortages, or significant delays in shipping, associated with the following vaccines: DTaP, Td, DT, Conjugated Pneumococcal vaccine, MMR, and Varicella vaccine. The shortages and delays are affecting both the private and publicly purchased vaccine systems. Based on information provided to the Immunization Program and CDC, we are able to make some estimates regarding when the supply situation will return to a more normal state. The individual vaccines are discussed below. Where applicable any restrictions put in place on the use of VFC vaccines are included.

The shortage of DTaP and Td has been an ongoing problem for over a year. Wyeth-Lederle's abrupt withdrawal from the market started the problem. In 2001, Aventis decreased production of DTaP as they transitioned to a thimerasol-free product. Aventis reduced the amount of vaccine they are shipping to physicians and temporarily suspended sales off the CDC contract. This was especially significant in Tennessee as approximately 60% of infants and children in the state are immunized with publicly purchased vaccines. The supply of DTaP, Td, and DT will be significantly improved by late spring or early summer. Smith-Kline continues to supply virtually all the publicly purchased DTaP and is working with CDC and the states to avoid distribution inequities. Aventis is increasing their production of DTaP (Tripedia) and has petitioned the FDA to allow use of the DTaP product the company distributes in Canada. If all goes as expected, DTaP vaccine would be available at normal or near normal levels by late spring or early summer. Aventis will begin allowing routine vaccine purchases through the CDC (VFC) contract, in the summer. The VFC program has restricted use of the VFC vaccine to primary doses only for both private and public providers.

The MMR vaccine is in short supply due to Merck's voluntary interruptions of production in the fall of 2001. These stoppages were partly a response to issues raised by the FDA and partly the result of scheduled modifications to their facility. This information was not communicated to CDC for several weeks after the stoppage. To help address the shortfall of MMR vaccine, the CDC loaned Merck 700,000 doses from the national emergency stockpile. Merck states they are now filling orders for MMR, but it is taking approximately 60 days for vaccine to be delivered. Delivery of MMR is expected to return to normal by the summer of this year. The VFC Program will restrict the use of program-supplied MMR vaccine to the first dose only for private and public providers effective in mid-February.

The situation with varicella vaccine has not been clarified, and significant delays are expected at least into the summer. Varicella vaccine orders take 60 days or more to be shipped. Representatives of Merck are evaluating their production and shipping capacity for varicella vaccine. At this time, there are no restrictions on the use of VFC purchased vaccine.

The demand for the conjugated S. Pneumonia vaccine (Prevnar) has completely outstripped production forcing most physicians and clinics to limit the number of doses children receive. Wyeth is attempting to increase production and expects to be able to supply sufficient vaccine to return to the routine schedule in the spring or summer. The requirement for Prevnar for day care attendance was suspended and will not be put into effect until January 1, 2003. The VFC program has restricted the use of program supplied vaccine to two doses for children under age 12 months. Children with high-risk medical conditions can continue to receive four doses of the vaccine.

HIB vaccine is generally available, especially the four dose vaccines (ActHIB and HIBTITER). Hepatitis b vaccine supplies are adequate, although the choice of brands may be limited. IPV vaccine is available without any restrictions. DT vaccine is available through local health departments. Td vaccine usage is indicated for wound management and for people who have never had a primary series of tetanus containing vaccine. This shortage is expected to abate by late spring or early summer.

2002 Calendar

Jun 21-23	FL-AAP Annual Meeting	Lake Buena Vista, FL
Sep 13-14	TNAAP Annual Meeting Open Forum	Knoxville
Sep 14	TNAAP Board Meeting	Knoxville
Sep 14	TNAAP Awards Dinner	Knoxville

* All Chapter members are invited to attend the Board meetings, but please let the Chapter office know at least 2 weeks in advance.

The Voice of a Pediatrician

Alison Asaro, MD and Buddy Creech, MD
Pediatric Residents, Vanderbilt Children's Hospital

Although we do not always realize it, we, as pediatricians, are trained to be child advocates. For many of us, this role is achieved in the office setting where we may encourage parents to stop smoking or provide better nutrition for their children. This role, however, can extend far beyond the office environment.

As part of our residency program at Vanderbilt Children's Hospital, we had the pleasure of spending February with Catherine Fenner, the Executive Director of the Tennessee Chapter of the AAP. Since the state legislature was in full swing, most of our time was spent investigating and commenting on bills that would affect the children of Tennessee. We were humbled at the response that legislators and lobbyists gave us, as they actively sought our opinions regarding medically-oriented bills and wanted us to work with them to draft legislation that was more effective and more child-friendly. As a result, we found that one or two voices really do make a difference. An example of this was a bill which would allow trained teachers to administer glucagon to diabetic students in the event of profound hypoglycemia. Without our input regarding the dangers of hypoglycemia in diabetic children and the ease of glucagon administration by trained persons, the legislators were prepared to vote on something they knew nothing about. We were also able to work on issues such as vision screening, child-care ratios, and TennCare.

We encourage you, as we were by Cathy, to realize your full potential as child advocates, particularly within state and local government. Please use your voice to support the well-being of Tennessee's children and pediatricians.

2001 Legislator of the Year, Rep. Kim McMillan with FNAAP Executive Director Cathy Fenner (left) and pediatric resident legislative interns, Dr. Alison Asaro and Dr. Buddy Creech (right).

THE NEWBORN OFFICE VISIT - How to Code

Joel F. Bradley, MD, FAAP, CPT Coding Advisor
(w) 615-936-6053

Many pediatricians now follow the AAP recommendation given in this year's preventive medicine guidelines (found on the AAP website under Policies) to see all breastfeeding babies within 2-3 days of discharge. This, coupled with the existing recommendation to see all babies back by 48 hours who had an early discharge from the nursery, creates a need to know how to properly code for these visits.

TennCare- These visits, if comprehensive in nature, are coded just like the subsequent well baby visits at two weeks and two months - a 99391 (established patient, 0-1 year of age) or 99381 (new patient, 0-1 year of age). These are then counted as an EPSDT visit, and as discussedon page 8 are usually reimbursed at a higher rate than routine problem-oriented office visits (i.e., 99213 etc). Even though most of these visits will be comprehensive in nature, if a patient is seen for a problem or illness only, use the office visit outpatient codes letting the level of history, physical, and medical decision-making decide the code level, not the age.

Private Payers- Coding should be as stated above, although some plans have not yet incorporated these visits into their schedule of preventive medicine benefits, and unlike the TennCare MCO's, may limit the total number of well visits in the first year. If one decides to code this visit as an office visit, usually in order to be reimbursed, a diagnosis code that is not a V code will need to be used (i.e., 99214 linked to a code for jaundice-774.6). If one uses the preventive medicine code, then the V codes are appropriate.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

This Year's National AAP "Outstanding Large Chapter"

Tennessee Chapter
P.O. Box 159201
Nashville, TN 37215

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Attachment V
TNAAP letter to Manny Martins regarding Pediatric Formulary

Tennessee Chapter of the
American Academy of Pediatrics
Tennessee Pediatric Society

DEDICATED TO THE HEALTH OF ALL CHILDREN™

1998 Year, National AAP Outstanding Large Chapter

P. O. Box 159201
Nashville, Tennessee 37215-9201
Telephone: (615) 383-6004
Fax: (615) 383-7170
E-mail: tnaap@aol.com
www.tnaap.org

November 25, 2002

Mr. Manny Martins, Deputy Commissioner
Bureau of TennCare
729 Church Street
Nashville, TN 37247-6501

Dear Mr. Martins:

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) is very pleased about the announcement of plans for a single formulary for TennCare. We commend you and your staff for the decision to implement this change, which has tremendous potential to improve patient care, reduce "hassles" for providers and to save money which could be used for additional health care services. We are eager to work with you in developing that part of the common formulary which applies to children.

You are probably aware that, for the last six months or so, we have, under the auspices of the Children's Health Initiative, been exploring the development of a common pediatric formulary with Dr. Conrad Shackleford and Mr. Leo Sullivan. In subsequent conversations with them, we were very pleased to learn that TNAAP will have a seat on the committee, which will be charged with "hands-on" development of the new formulary. We believe that the implementation of the new formulary will be much more effective in the pediatric community if TNAAP has active input in its actual development. Involving those physicians who actually treat the children in the development of the formulary's pediatric component will improve the quality of care they can provide and is likely to result in greater usage by those providers upon its implementation.

The purpose of this letter is to reconfirm our commitment to this process and to explain the steps we have already taken regarding this initiative:

1. The Chairpersons of the Departments of Pediatrics at the University of Tennessee Health Science Center in Memphis and at Vanderbilt University Medical Center have committed the support of their faculties, especially sub-specialty pediatricians, to the development of a Common Pediatric Formulary (CPF);

2. A pediatric pharmacist, who is a member of the faculties of both the College of Medicine (Pediatrics) and the College of

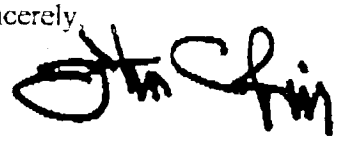
Pharmacy, has been identified as a provider qualified and willing to review doses and formulations with regards to optimal practice for children;

3. The American Academy of Pediatrics Committee on Drugs is supportive of this initiative, emphasizing the opportunity this could provide to utilize FDAMA-generated pharmacologic data. Of note is that a contract, currently being finalized between that organization and the federal Food and Drug Administration, contains provisions that could support the pediatric portion of our common formulary as a pilot project; and

4. Preliminary work has begun to construct the common pediatric formulary drug list (identify the "top five" drugs, together with preferred formulations, for each provider group).

We remain enthusiastic proponents of a common formulary for TennCare recipients and feel that, with appropriate input from TNAAP, this will improve pharmacy services for children and reduce "hassles" for providers and the state alike. This is the type of initiative that builds faith in the program and may lead to increased provider participation. We are not invested in any particular way of developing a common formulary that applies to children, but we remain firmly committed to the process, provided that our input is given the careful consideration it deserves. We look forward to expanding our dialogue in this regard, as a meaningful service to the children of the State and their providers.

Sincerely,



John C. Ring, MD, FAAP
President

cc: *Conrad Shackleford, MD*
Joe McLaughlin, PhD
Leo Sullivan, TennCare Pharmacy Director
Governor-Elect Phil Bredesen
Representative Gene Caldwell, MD

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B., CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTIN P. by his next friend, Linda C.; BAYLI S. by her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)	
Plaintiffs,	)	
v.	)	No. 3-98-0168
	)	Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)	
Defendants.	)	

JANUARY 2003 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel regarding their compliance with the terms of that order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable

audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order . . ."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending January 31, 2003. Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' counsel.

Respectfully submitted,

PAUL G. SUMMERS
Attorney General and Reporter

Linda A. Ross

LINDA A. ROSS
Deputy Attorney General
STEVEN B. CARTER
Assistant Attorney General
Office of the Tennessee Attorney General
Health Care Division
Cordell Hull Building, 2nd Floor
425 5th Avenue North
Nashville, Tennessee 37243
(615) 741-1771
Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been forwarded by first-class U.S. Mail, postage prepaid, to:

Gordon Bonnyman
Michele Johnson
Tennessee Justice Center
211 Union Street
916 Stahlman Building
Nashville, Tennessee 37201
Counsel for Plaintiffs

Dr. Richard Carter
Office of the Special Master
Nashville House
One Vantage Way, Suite E-210
Nashville, Tennessee 37228

on this, the 31st day of January, 2003.

Linda A. Ross
LINDA A. ROSS

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: Linda Ross, Assistant Attorney General

FROM: Manny Martins, Deputy Commissioner

SUBJECT: John B. Semi-Annual Report

DATE: January 31, 2003

Attached is the Semi-Annual Report for the period of August 1, 2002 through January 31, 2003. Please call me if you have any questions.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

OFFICE OF CONTRACT DEVELOPMENT AND COMPLIANCE

EPSDT SEMI-ANNUAL REPORT

JULY TO DECEMBER 2002

ATTACHMENT A.

Member Handbooks- Medicaid and Standard
Reviewed by: Jena Napier, Marketing Coordinator
For EPSDT- July 01, 2002 to December 31, 2002
Office of Contract Development and Compliance

MCO Name	Document	Date Received	Date Approved	Revisions
Better Health	Medicaid Member Handbook	11/06/02	01/13/03	Yes
Better Health	Standard Member Handbook	11/06/02	01/13/03	Yes
BlueCare	Medicaid Member Handbook	10/01/02	12/09/02	Yes
BlueCare	Standard Member Handbook	10/01/02	12/09/02	Yes
Doral Dental	Medicaid Member Handbook	08/07/02	09/27/02	Yes
Doral Dental	Standard Member Handbook	11/08/02	12/03/02	Yes
John Deere	Medicaid Member Handbook	11/04/02	12/13/02	Yes
John Deere	Standard Member Handbook	11/12/02	12/13/02	Yes
OmniCare	Medicaid Member Handbook	10/04/02	12/13/02	Yes
OmniCare	Standard Member Handbook	10/04/02	12/13/02	Yes
PHP	Medicaid Member Handbook	09/17/02	01/13/03	Yes
PHP	Standard Member Handbook	09/17/02	01/22/03	Yes
TennCare Select	Medicaid Member Handbook	11/20/02	12/13/02	Yes
TennCare Select	Standard Member Handbook	11/20/02	12/13/02	Yes
TLC	Medicaid Member Handbook	10/24/02	*****	Yes
TLC	Standard Member Handbook	10/24/02	*****	Yes
Universal Care	Medicaid Member Handbook	11/21/02	12/27/02	Yes
Universal Care	Standard Member Handbook	11/21/02	12/27/02	Yes
VHP	Medicaid Member Handbook	11/01/02	12/13/02	Yes
VHP	Standard Member Handbook	11/01/02	12/13/02	Yes
Xantus	Medicaid Member Handbook	11/12/02	01/07/03	Yes
Xantus	Standard Member Handbook	11/14/02	01/13/03	Yes

***** = Files are still outstanding and revisions have been requested.

The Bureau of TennCare requested each MCO to submit two handbooks due to the new wavier which became effective July 1, 2002. One handbook is a Medicaid Member Handbook and the other is a Standard Member Handbook.

Additional Marketing Materials on EPSDT
Reviewed by: Jena Napier, Marketing Coordinator
For EPSDT- July 01, 2002 to December 31, 2002
Office of Contract Development and Compliance

MCO Name	Document	Date Received	Date Approved	Revisions
Better Health	EPSDT Flyer	07/03/02	07/30/02	Yes
BlueCare	EPSDT- "Keep Your Child Healthy" Brochure	10/17/02	11/01/02	No
BlueCare	EPSDT- "Did You Forget?" Postcard	10/23/02	11/06/02	No
BlueCare	EPSDT- Envelopes	11/05/02	11/20/02	No
BlueCare	EPSDT- Poster Contest	06/21/02	07/08/02	No
John Deere	EPSDT- Postcard	10/22/02	11/12/02	Yes
OmniCare	EPSDT- Letter and Form	08/14/02	09/09/02	Yes
TennCare Select	EPSDT- "Keep Your Child Healthy" Brochure	10/17/02	11/01/02	No
TennCare Select	EPSDT- "Did You Forget?" Postcard	10/23/02	11/06/02	No
TennCare Select	EPSDT Envelopes	11/05/02	11/20/02	No
TennCare Select	EPSDT- Poster Contest	06/21/02	07/08/02	No
TLC	EPSDT- Poster	08/05/02	08/28/02	Yes
TLC	EPSDT- Past Due Preventive Service Visits	09/30/02	10/21/02	Yes
TLC	EPSDT- Brochure for ages 10-14	11/06/02	12/06/02	Yes
TLC	Winter Newsletter to include EPSDT	10/28/02	11/13/02	No
TLC	Beeper Incentive for EPSDT	10/23/02	11/05/02	No
TLC	EPSDT- Rap Jingle	10/01/02	12/17/02	Yes
Universal Care	Phone Campaign on EPSDT	11/15/02	11/22/02	No
VHP	EPSDT- Member Letter	08/07/02	09/11/02	Yes
VHP	EPSDT- Follow Up Letter	10/03/02	10/30/02	Yes
Xantus	EPSDT Outreach	07/29/02	08/28/02	Yes

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

OFFICE OF CONTRACT DEVELOPMENT AND COMPLIANCE

EPSDT SEMI-ANNUAL REPORT

JULY TO DECEMBER 2002

ATTACHMENT B.

Bureau of TennCare
Office of Contract Development & Compliance

EPSDT TRANSPORTATION REVIEW CHECKLIST

Name of MCC: _____

Name of OCDC Reviewer: _____

Date of Review: _____

Title of Document Reviewed: _____

Date of Document: _____

INTRODUCTION:

This EPSDT Transportation Review Checklist is intended to be a guide and is not all inclusive. It is an attempt to ensure that MCC Member Handbooks, Provider Manuals, EPSDT Marketing Materials, Transportation Policies and Procedures, and Transportation Vendor Subcontracts contain the required language for transportation.

Definition of EPSDT:

EPSDT Services (Early Periodic Screening, Diagnosis and Treatment) of Individuals under age 21 made pursuant to 42 U.S.C. Sections 1396a (a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or an individual basis) physical and mental defects, and providing treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

Reference Documents:

Yes ❑ No ❑ N/A ❑ **John B. Consent Decree:**

Section _____ Page _____

Paragraph 74. The defendants shall ensure that the MCOs meet their responsibilities to provide non-emergency transportation services under Daniels v. Wadley, No.79-3107-NA-CV (M.D.Tenn.).

Yes ❑ No ❑ N/A ❑ **MCO Contract Provision: Section 2-3.a.1.**

Section _____ Page _____

As necessary for enrollees lacking accessible transportation for covered services.

The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment.

EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be

		effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems. worsening of an individual's conditions or preventing the development of additional health problems.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

Section 2-3.u.

2-3.u. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

Section 2-3.u.7.(a)(3)

The MCO must have a mechanism for notifying families when EPSDT screens are due. This mechanism must include an offer of transportation and scheduling assistance.

BHO Contract Provision: Section 2.6.8.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

2.6.8.1.4 Transportation and scheduling assistance.
Transportation assistance for a child includes related travel expenses, the cost of meals, and lodging in route to and from care, the cost of an attendant to accompany a child if necessary.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

2.6.8.5 The Contractor shall offer transportation and scheduling assistance to all children under age 21 referred for a mental health or substance abuse assessment.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

2.6.8.6. In the event that the child's parent or legal guardian is unable to accompany the child to the examination, the Contractor shall require providers to contact the child's parent or legal guardian to discuss the findings and inform the parent or legal guardian of any other necessary health care, diagnostic services, treatment or other measures recommended for the child, or notify the BHO to contact the family with the results.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

John B. Consent Decree:

Paragraph 75. The defendants shall prohibit MCOs from imposing blanket restrictions or requirements on transportation to plaintiff class members because of their age or lack of parental accompaniment.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

MCO Contract Provision: Section 2-3.u.1.(b)(9)

2-3.u.1.(b) (9). Transportation assistance for a child includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary. Blanket restrictions may not be imposed when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case by the CONTRACTOR and documented by the CONTRACTOR and/or the transportation vendor.

The requirement to provide the cost of meals shall not be interpreted to mean that an enrollee and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when an enrollee has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

DISCLAIMER: This checklist form is not intended to be all inclusive for all situations. Rather, it is a guide.

The CONTRACTOR shall offer transportation and scheduling assistance to all children under age 21 referred for an assessment that do not have access to transportation. This may be accomplished through various means of communication to enrollees, including but not limited to, member handbooks, EPSDT outreach notification, etc.

An EPSDT enrollee may be considered for transportation if such enrollee has written permission from the treating physician and custodial parent(s). Circumstances that may permit the CONTRATOR and/or its transportation vendor to refuse the transportation request would be as follows.

(i) The EPSDT enrollee is under the age of eighteen (18) and does not have an attendant.

(ii) The EPSDT enrollee has an attendant, but the attendant is not a parent or legal guardian and cannot legally sign for the enrollee or stepchild. Some foster or stepparents do not have legal authority to sign for medical care for foster or step children. The CONTRACTOR and transportation vendors must be aware of this and must ask these questions when scheduling transport.

(iii) The enrollee or attendant according to a reasonable person's standards has to be noticeably indisposed [disorderly conduct, intoxicated, armed (firearms), possession of illegal drugs, knives and/or other weapons], and in any other condition that may affect the safety of the driver or persons being transported.

Yes ❑ No ❑ N/A ❑

Section _____ Page _____

John B. Consent Decree:

Paragraph 76. The defendants or their contractors shall provide non-emergency transportation in accordance with 42 U.S.C. Section 1396d (a) (25); 42 C.F.R. Section 440.170(a), 441.62; State Medicaid Manual Section 5150. Transportation assistance includes "related travel expenses," cost of meals and lodging in route to and from care and the cost of an attendant to accompany a child if necessary.

Monitoring of BHO Provided Services for DCS Children
October 2002

This report describes the services provided to children in DCS custody. The population includes all children in DCS custody through March 31, 2002 who are SED/SPMI (n = 3,236), and non-priority children (n = 9,577). The data include encounter claims from July 1, 2000 through March 31, 2002, case management logs, and DCS eligibility information from October 2001 to September 2002. Data for children in DCS custody who are receiving treatment in a level 3 or 4 facility, much of which is administered directly by DCS, are not necessarily represented in the encounter data.

Report Highlights:

- There have been 12,813 children in DCS custody sometime between October 1, 2001 and March 31, 2002.
- Of the children in DCS custody, 25% are categorized as priority population.
- 7.8% of the children in DCS custody received a psychiatric inpatient admission.
- Less than 1% of the children in DCS custody received a residential treatment admission.
- 80% of the priority children and 33% of the non-priority children in DCS custody received outpatient services (other than mental health screens).
- 62% of the priority children and 26% of non-priority children in DCS custody received one or more mental health screens at some point between July 1, 2000 and March 31, 2002.
- 33% of the children in DCS custody received mental health case management services at some point from July 2000 to March 2002. This percentage is projected to increase as the BHO and DCS work to ensure that all priority children in DCS custody are offered mental health case management.

Inpatient Utilization

The inpatient encounter data included in this report refer only to the number of admissions to a psychiatric inpatient facility. The table below, *Inpatient Utilization for Children During DCS Custody*, displays the number of unduplicated priority and non-priority children with at least one psychiatric inpatient admission during their time in DCS custody divided into age categories.

Inpatient Utilization for Children During DCS Custody (N = 681)		
	Non-Priority Children	Priority Children
Number of Unduplicated Children	245	436
Age 4 to 12	31 (12.7%)	79 (18.1%)
Age 13 to 17	144 (58.8%)	294 (67.4%)
Age 18 to 20	70 (28.6%)	63 (14.4%)

The inpatient service utilization data reveal the following:

- 681 children have experienced at least one psychiatric inpatient admission during their time in custody.
- 64% of the children in custody with a psychiatric inpatient admission were categorized as SED/SPMI.

The following table, *Inpatient Length of Stay per Admission for Children During DCS Custody*, shows the average and median length of stay by days for the non-priority and priority children who had an inpatient admission.

Inpatient Length of Stay per Admission for Children During DCS Custody		
	Average of Days	Median of Days
Non-priority	8.7	6
Priority	10.4	7

The chart provided on the following page illustrates the inpatient utilization for those children who received a psychiatric inpatient admission during their time in DCS custody. These charts show the trends between October 2001 and March 2002 by month.

Residential Treatment Utilization

The data regarding 24-hour residential treatment reveal the following:

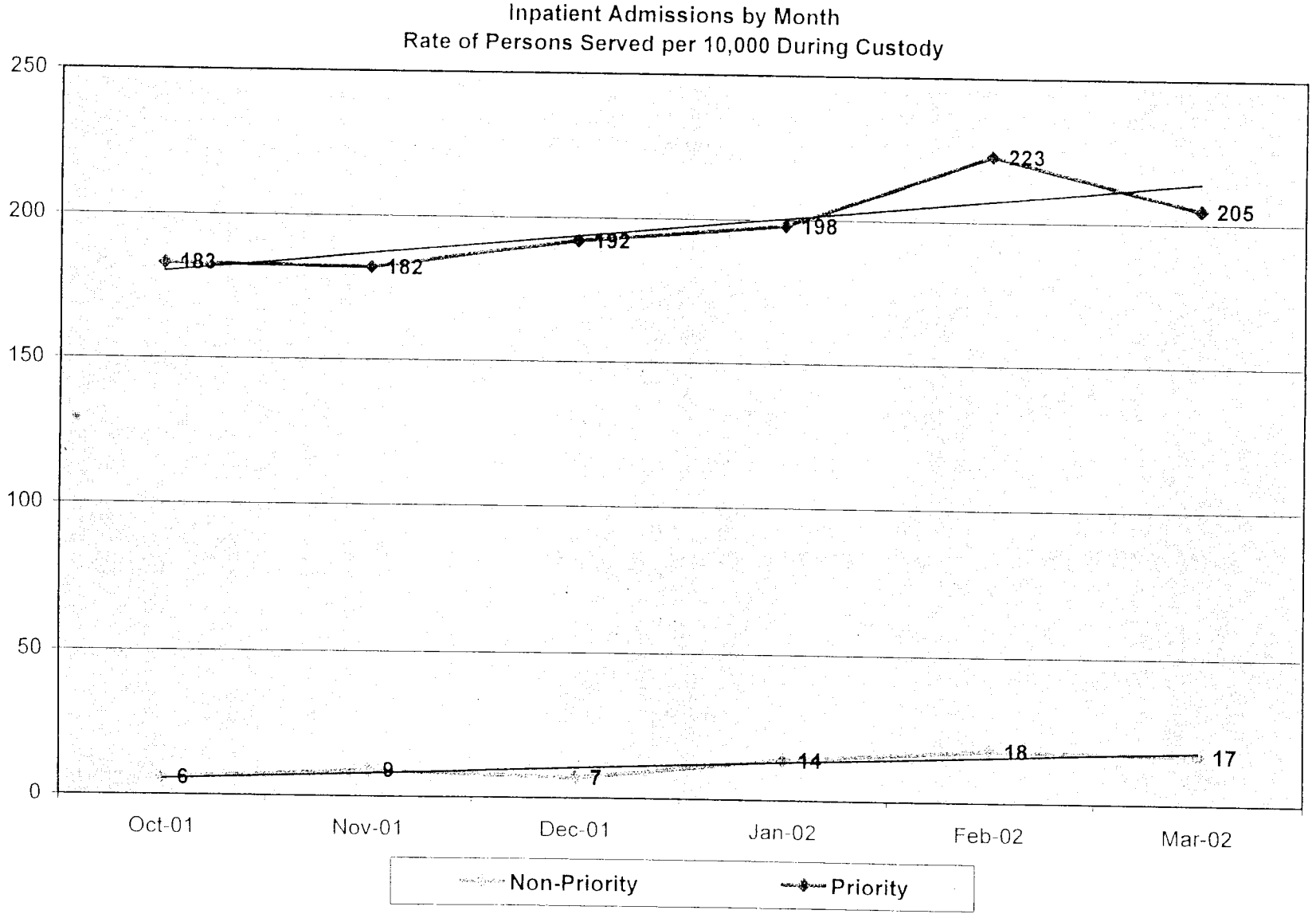
- 7 children received at least one residential treatment admission during their time in DCS custody.
- Of those 7 children, 4 (57%) were categorized as non-priority children and 3 (43%) were categorized as priority children.

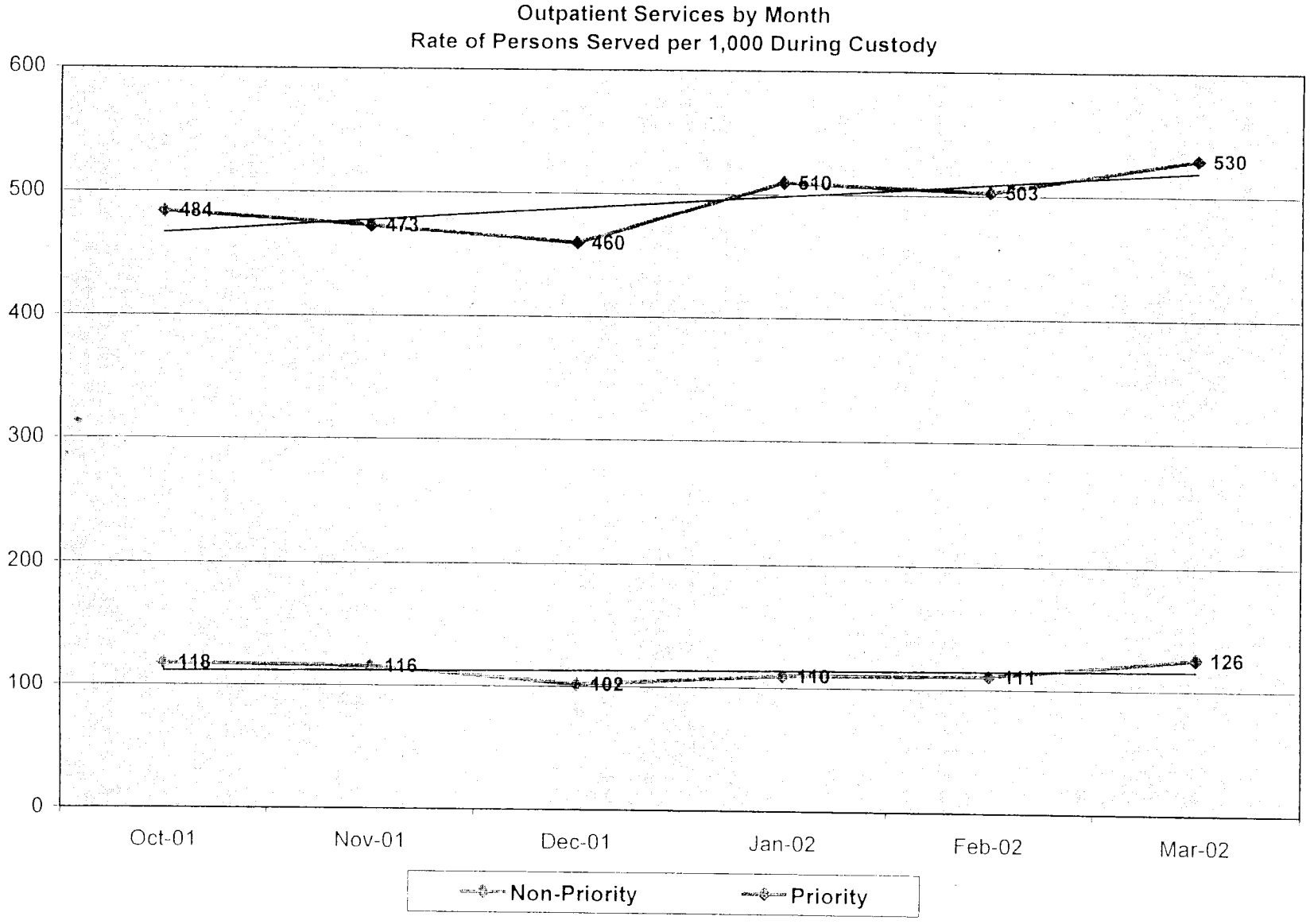
Outpatient Utilization

The table below, *Outpatient Service Utilization for Children in DCS Custody*, indicates the number of children who utilized any outpatient service between July 1, 2000 and March 31, 2002 divided into age categories.

Outpatient Service Utilization for Children During Time in DCS Custody (N = 6288)		
	Non-Priority Children	**Priority Children**
Number of Children (Unduplicated)	3554	2734
Under 4 years	26 (.7%)	7 (.3%)
Age 4 to 12	1034 (29.1%)	773 (28.3%)
Age 13 to 17	1716 (48.3%)	1619 (59.2%)
Age 18 to 20	772 (21.7%)	329 (12.0%)
Age 21 and over	6 (.2%)	6 (.2%)

The chart provided on the following page shows the outpatient utilization for non-priority and priority children who received an outpatient service during their time in DCS custody. The chart shows the trends of outpatient services by month between October 2001 and March 2002. According to the outpatient data, the number of outpatient services being received by priority children appears to be increasing over time while the outpatient services for non-priority children appears to be remaining the same.


Inpatient Admissions by Month
Rate of Persons Served per 10,000 During Custody
250
200
150
100
50
0
183
182
192
198
223
205
6
9
7
14
18
17
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
Non-Priority
Priority

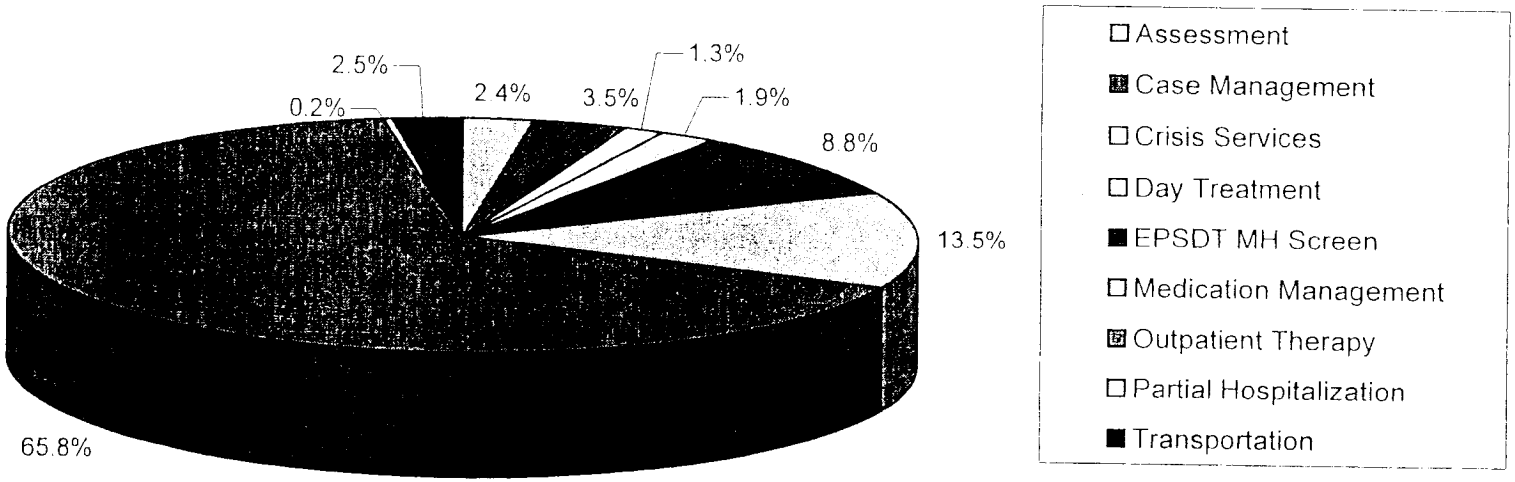

Outpatient Services by Month
Rate of Persons Served per 1,000 During Custody
600
500
400
300
200
100
0
484
473
460
510
503
530
118
116
102
110
111
126
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
Non-Priority
Priority

Outpatient Utilization by Selected Service Types for Children During Time in DCS Custody Between 07/01/00 and 03/31/02				
	Non-Priority Children		Priority Children	
	Number of Services	Number of Children	Number of Services	Number of Children
Assessment	1,117 (2.4%)	585	1,539 (3.1%)	771
Case Management	1,663 (3.5%)	345	4,454 (8.9%)	722
Crisis Services	617 (1.3%)	306	1,389 (2.8%)	526
Day Treatment	885 (1.9%)	20	1,360 (2.7%)	37
EPSDT	4,139 (8.8%)	2,445	4,077 (8.1%)	2,020
Medication Management	6,345 (13.5%)	1,300	8,339 (16.6%)	1,556
Outpatient Therapy	30,857 (65.8%)	2,461	27,472 (54.7%)	2,028
Partial Hospitalization	75 (0.2%)	11	211 (0.4%)	22
Transportation	1166 (2.5%)	96	1,337 (2.7%)	80

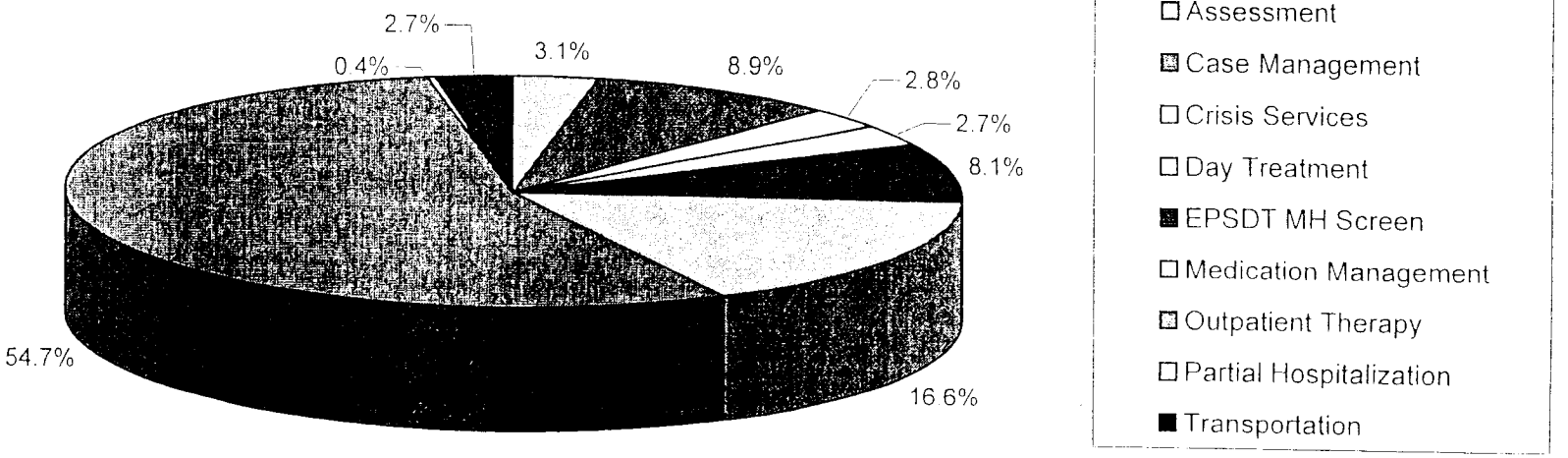
The *Outpatient Utilization by Selected Service Types* table for non-priority and priority children provides information regarding the total number of outpatient services provided to children during their time in custody by the service types. Additionally, the tables indicate the actual number of children who received a specific type of outpatient service. For example, according to the outpatient data for non-priority children during custody, there were 1,663 mental health case management claims (for 345 unique children) during the period of July 1, 2000 through March 31, 2002. The same table also indicates that for priority children during their time in custody, there were 4,454 mental health case management claims (for 722 unique children) during the same time period. According to the data above, outpatient therapy is the most utilized service for both priority and non-priority children. Non-priority children averaged 12.5 outpatient services and priority children averaged 13.5 outpatient services during their time in custody.

The chart provided on the following page shows the distribution of outpatient services provided for non-priority and priority children during their time in DCS custody.

Outpatient Service Types for Non-Priority Children During Custody



Outpatient Service Types for Priority Children During Custody



An analysis was conducted of EPSDT mental health screenings and of the other outpatient services provided in which EPSDT mental health screenings (CPT code 90801) were excluded. The analysis revealed the following:

Outpatient Services and EPSDT Mental Health Screenings		
	Number of Children with At Least One Outpatient Service (Excluding Mental Health Screens)	Number of Children with At Least One EPSDT Mental Health Screen
Non-Priority	3193	2445
Priority	2573	2020

Analysis regarding those children who have received an EPSDT mental health screening indicates the following:

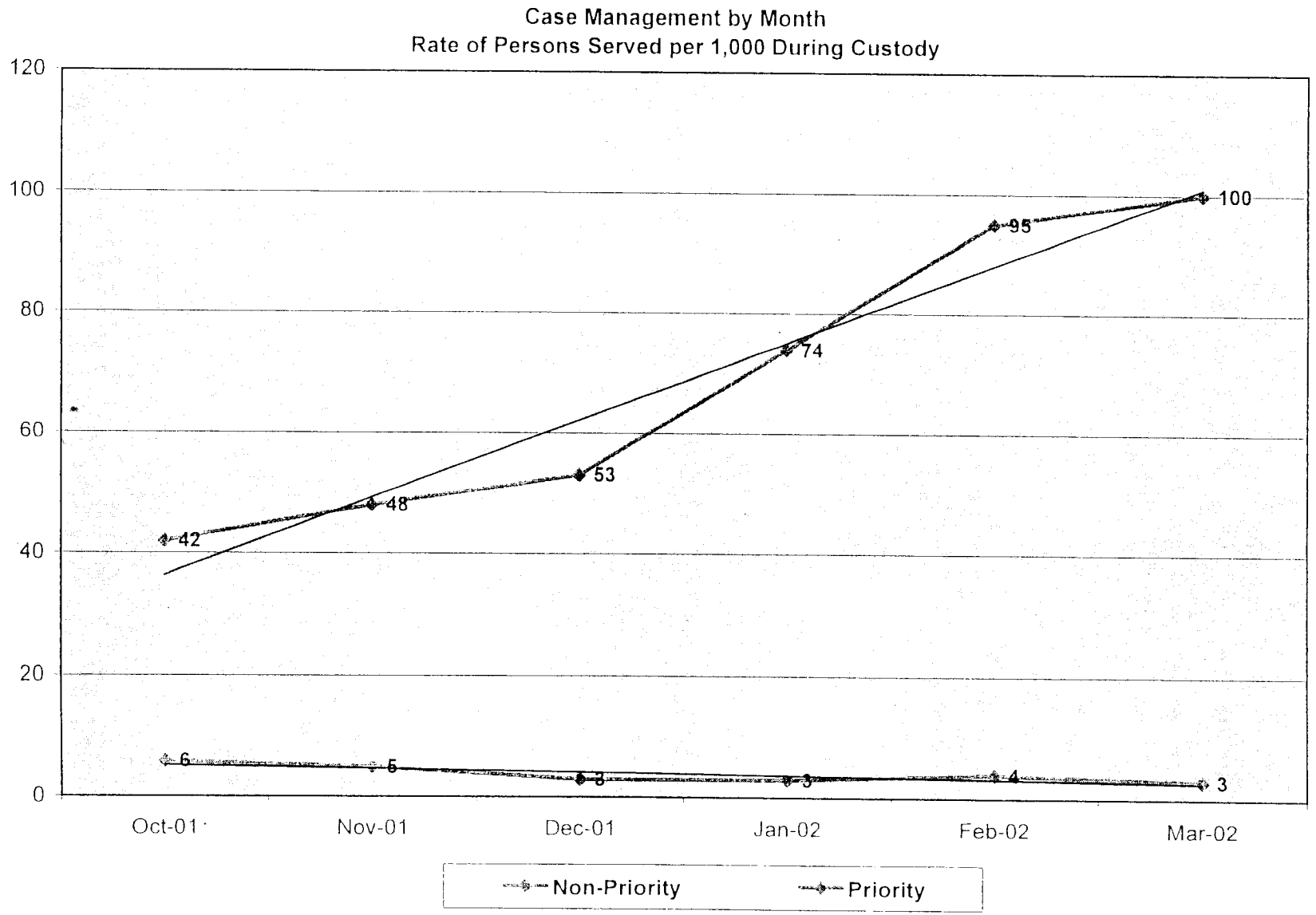
- Overall, 62% of children with a priority assessment in DCS custody (n = 3236) have received an EPSDT mental health screen as compared to only 26% of non-priority children in custody.
- 80% of priority children have received at least one outpatient service, other than mental health screens, during their time in DCS custody as compared to only 33% of non-priority children.

Case Management

The data reviewed regarding mental health case management services reveal the following:

Active Case Management	
	Number of Children with At Least One Active Case Management Service
Non-Priority	345
Priority	722

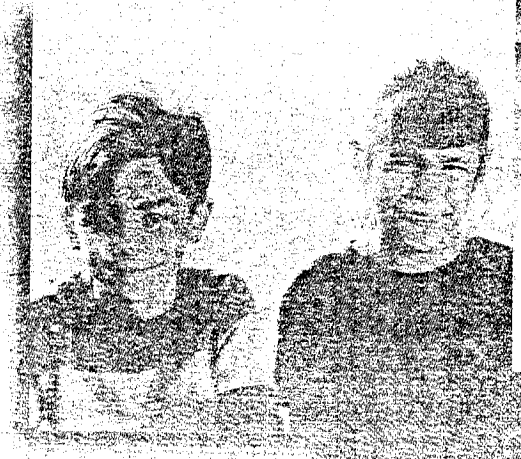
The following chart shows the trends of active case management encounters for non-priority and priority children from October 2001 through March 2002:


Case Management by Month
Rate of Persons Served per 1,000 During Custody
120
100
80
60
40
20
0
Oct-01
Nov-01
Dec-01
Jan-02
Feb-02
Mar-02
42
48
53
74
95
100
6
5
3
3
4
3
Non-Priority
Priority

- 55 children received Continuous Treatment Team (CTT) intensive case management services during their time in DCS custody.
- 24 of those who received CTT during their time in custody have been discharged from CTT services.
- One child in DCS custody received Comprehensive Child and Family Treatment (CCFT) and has been discharged.
- Overall, 93 children discontinued case management services and 73 children were offered case management services but declined the service[1].

[1] The number of declines for case management services are under reported in the encounter data by as much as 80%.

Best Practice Guidelines



Behavioral Health Services For Children and Adolescents

Tennessee
Department of Mental Health
and Developmental
Disabilities

July 2002

Tennessee Department of Mental Health and Developmental Disabilities
Best Practice Guidelines
Behavioral Services for Children and Adolescents

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The American Academy of Child and Adolescent Psychiatry
Expert Consensus Guidelines Series, LLC.

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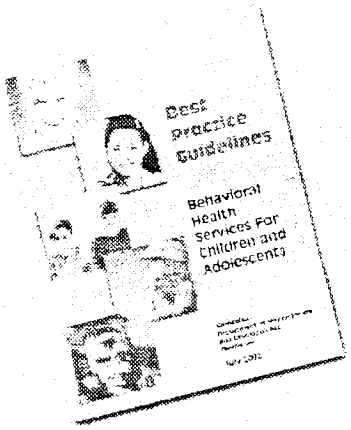

Best Practice Guidelines For Children and Adolescents

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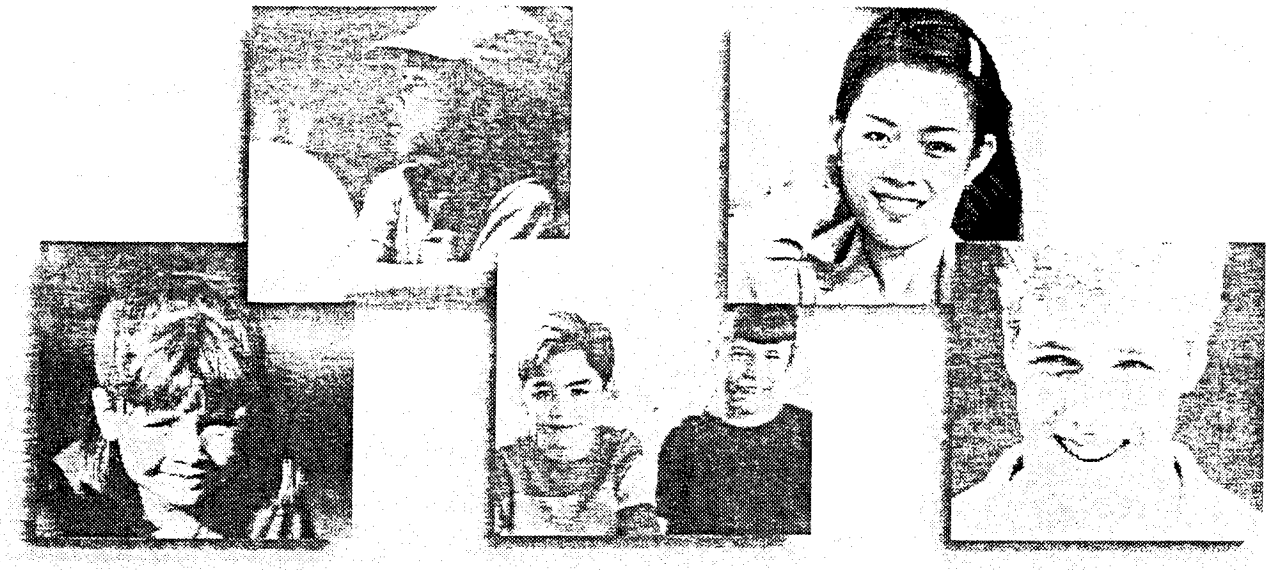


TDMHDD GUIDELINE

Attention-Deficit/Hyperactivity Disorder

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children between five and twelve years of age with "typical" ADHD in the primary care office. Material herein was prepared by Jerry Heston, M.D., University of Tennessee College of Medicine, based on current understanding of the disorder and coordinated with recommendations from professional organizations, primarily the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. The goal of the protocol is to improve the care of children with this disorder. It is not intended to dictate treatment decisions but to provide practitioners, especially those in primary care, with information and support as they care for children with ADHD. Complex cases, cases with significant comorbidity or presentations outside the "typical" age range are beyond the scope of this protocol. Nonetheless, the protocol may serve as a base for modifications in these complicated cases.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, override the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

AND

_____ there is *clear evidence* of clinically significant impairment in social, academic or occupational functioning

AND

_____ the symptoms do not occur only in the course of a pervasive developmental disorder, a psychotic disorder, and/or are not better accounted for by a physiological condition, or by another mental disorder (i.e, Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder)

Confirm Diagnosis Of ADHD With Direct Information From Parents And Teachers Or Other Caregivers:

Request completion of ADHD-specific rating scales (ex.: Abbreviated Conners Scale) by parents and teachers.

Review school-based multidisciplinary evaluations or other school reports and assessments.

Evaluate Presence Of Comorbid Conditions And Differential Diagnoses:

Learning Disabilities may exist where there is irregular achievement in school or when academic functioning is less than might be expected based on service recipient's overall intellect. In about 30% of cases of ADHD, there is an existing learning disability, but it should also be noted that learning disability can often mimic ADHD, especially **inattentive type.** Refer for psycho-educational testing to confirm.

Oppositional Defiant Disorder and **Conduct Disorder** may co-occur with ADHD in about 30% of service recipients. Hallmarks include high levels of defiance or other severely disruptive behavior beyond overactivity and poor attention skills. Consider consultation or referral to mental health care provider for diagnosis and treatment.

Anxiety Disorders with prominent worries, fears and tension may coexist with ADHD. The restlessness and fidgetiness of Anxiety Disorders may resemble ADHD and should be considered in the differential diagnosis. Consider consultation or referral to mental health care provider.

Depressive Disorders may coexist with ADHD, especially in service recipients who have experienced numerous failures or other stresses and have developed depressive thought patterns that begin to influence their outlooks. Some of these children may respond to support and experiencing success instead of failure. Others may require consultation or referral to mental health care provider. Depression is often seen in adolescents with ADHD who may not have been diagnosed and treated properly as younger children so that they have attributed their difficulties to bad behavior or other self problems rather than to a treatable condition. Some of these teens have turned to substance abuse as a means of self-medicating or as a means to a social group. Assessment of substance use/abuse should be included when considering adolescents with ADHD.

Various **social stressors** including adjustment problems, family disruption or physical and sexual abuse can both coexist and resemble the symptoms of ADHD. A careful and complete social history should be completed. Referral to mental health care providers or other agencies may be needed.

Plan B:
Lack of response to one stimulant does not indicate poor response to other stimulant medications. Therefore, start treatment with a second stimulant medication (amphetamine, if methylphenidate used in Plan A or vice versa). Methods of dosing and monitoring follow up are as in Plan A.

If poor response is seen, consider Plan C.

Plan C:
Consider treatment with pemoline (Cylert) a third available stimulant. Because of rare, fatal liver toxicity some clinicians may elect to bypass this step. Because of a longer half-life, once a day dosing is possible. Doses begin at 18.75 mg and may be increased in two to three weeks depending on response and side effects. Due to the longer half-life, response may take one to two weeks to occur. Frequent laboratory monitoring of hepatic enzymes (every two to three weeks) can be problematic and limits this option.

Plan D is considered by clinicians that opt against Plan C or for service recipients that do not respond to pemoline.

Plan D:
Tricyclic antidepressant medications have been shown to be useful in children with ADHD. Due to side effects, high overdose toxicity and poorer response rates than stimulants, these medications are thought of as third and fourth line medication interventions. Imipramine (Tofranil) is recommended. Due to possibly higher cardiac effects, desipramine (Norpramin) is not recommended. Pretreatment screening should include family history of cardiac arrhythmias, physical exam, general laboratory screens and an EKG. Side effects (sedation, increased appetite, tremors, and cardiovascular symptoms) are discussed with the service recipient and family. Dosing is started at 25 mg/day in once daily dosing.

The dose is gradually increased based on response and side effects. It may take one to two weeks to observe a clinical response, so dose should not be increased more frequently than weekly. Doses above 2-3mg/kg/day are associated with increased adverse events. Doses higher than this merit reconsideration of the diagnosis and consultation with specialists.

Response, including reports for school staff, should be monitored along with occurrence of side effects and overall functioning. EKG should be monitored throughout treatment, especially at increased doses.

Adjunct Therapies:

Various forms of counseling may be the major intervention for mild cases of ADHD. **Behavioral therapy** can be used to modify behavior using behavioral plans which target specific behavior, outline rewards and address how the plan is to be modified after success. **Family therapy** can be used to change family interactional patterns that may cause dysfunction and improve communication and other family functions to encourage the child with ADHD to rely upon his strengths. Parent training has been proven to be a very effective treatment for children with ADHD, especially when combined with appropriate medications, and parent support groups are an important adjunct to treatment. Various forms of **individual counseling** may be indicated for children with problems coping or other co-morbid conditions (e.g. social skills training). While general behavioral therapy may be done in the primary care office, other, more formal counseling and therapy, should be referred to a mental health care provider.

TDMHDD Guideline

Anxiety Disorders in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with anxiety disorders in primary care and behavioral health treatment settings. These guidelines are based on the following source material:

> *Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders*. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with anxiety disorders and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Posttraumatic stress disorder- *(see full guideline in this manual for additional information)*

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with Agoraphobia.

Therapy

Behavioral therapy targets the service recipient's overt behavior and emphasizes treatment within the context of family and school instead of focusing on the etiology of the behavior.

Cognitive-behavioral treatment integrates a behavioral approach with an emphasis on changing the cognitions associated with the service recipient's anxiety.

Psychodynamic psychotherapy derives from child psychoanalysis and includes a greater participation of the parents/caregivers and a more explicit use of active support, practical guidance, and environmental interventions. Therapy directed to fears and anxieties underlying the disorder is often an appropriate component of treatment.

Parent-child interventions may include helping parents/caregivers encourage children/adolescents to face new situations rather than withdrawing, refraining from excessive criticism and intrusiveness, responding to children's needs, and encouraging children to engage in activities despite anxiety. Infant-parent psychotherapy is recommended where there are attachment problems.

Family therapy is also used to disrupt the dysfunctional family interactional patterns that promote family insecurity and to support areas of family competence.

Psychoeducation is important in the treatment of panic disorder.

Pharmacological Treatment

Pharmacotherapy should never be used as the sole intervention. Pharmacotherapy should be used only as an adjunct to behavioral or psychotherapeutic interventions. Selection of the appropriate medication is primarily based on comorbid conditions if they exist. For a child/adolescent with ADHD or enuresis, a tricyclic antidepressant is the drug of choice. A child with comorbid obsessive-compulsive disorder would benefit the most from an SSRI. Side effect profile should also be considered when selecting medication therapy.

Benzodiazepines are often used on a short-term basis, and in the case of severe anxiety, benzodiazepines may be used in conjunction with an SSRI or TCA for several weeks until the antidepressant begins to show beneficial effects.

Treatment Steps

1. Determine onset and development of symptoms and the context in which the symptoms occur and are maintained.
   a. Is anxiety stimulus specific, spontaneous, or anticipatory?
   b. Is avoidant behavior present?
   c. Do comorbid symptoms exist?

11. Begin pharmacotherapy depending on the diagnosis and severity.
    a. separation anxiety disorder- in severe cases use a benzodiazepine +/- TCA* or SSRI
    b. other anxiety disorders- in severe cases use a benzodiazepine +/- TCA* or SSRI
    c. social phobia- SSRI
    d. other phobias- pharmacotherapy rarely used
    e. panic disorder- SSRI or TCA +/- benzodiazepine
    f. obsessive-compulsive disorder- SSRI or clomipramine
    g. posttraumatic stress disorder- antidepressant of choice

*Trazodone is often effective in these cases.

TDMHDD GUIDELINE

Bipolar Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with bipolar disorder symptoms in primary care and behavioral treatment settings. Portions of this guideline are adapted from the following sources:

> Practice parameters for the assessment and treatment of children, adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):157S-177S [120 references]
>
> Treatment algorithms incorporated within this guideline were developed by Catherine Fuchs, M.D., Vanderbilt University Medical Center.

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with bipolar disorder and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Evaluation

Diagnostic Assessment:

- *Premorbid history*
- *History of present illness*
- *Family history and dynamics*
- *School information*
- *Consultation and collaboration with other mental health and/or social service providers as necessary.*
- *Past medical history*

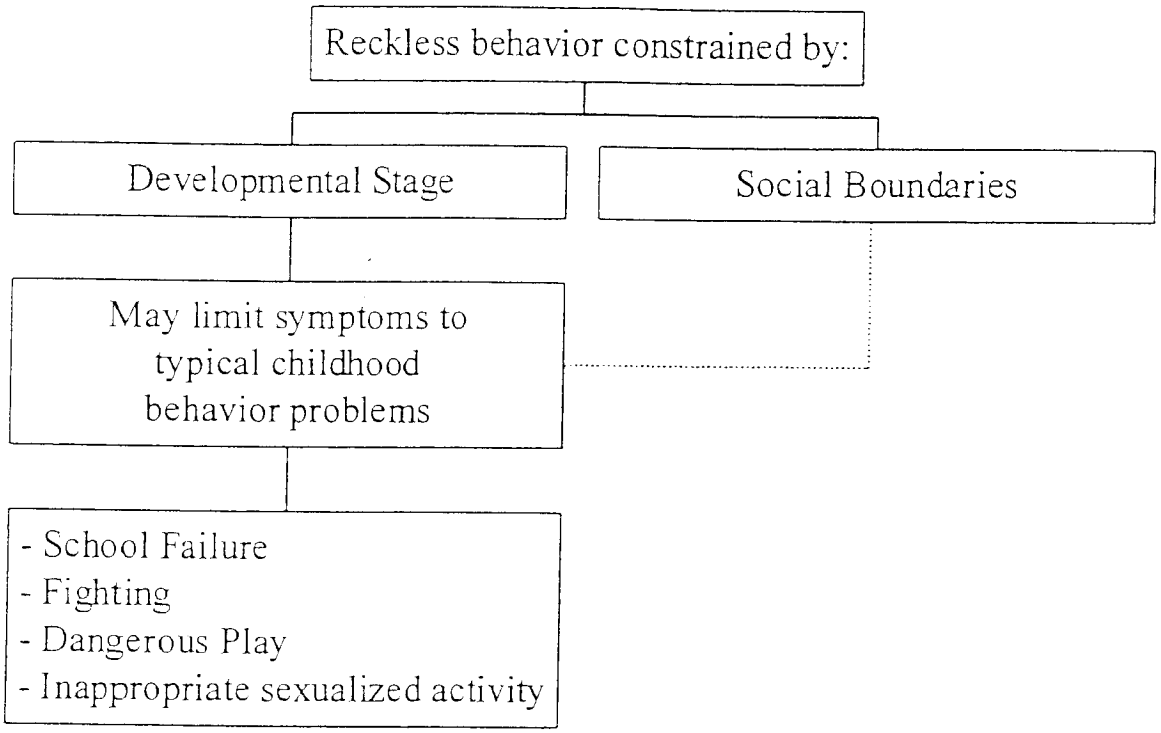
Assessment of suicide risk

Rule out other disorders and determine if necessary to hospitalize

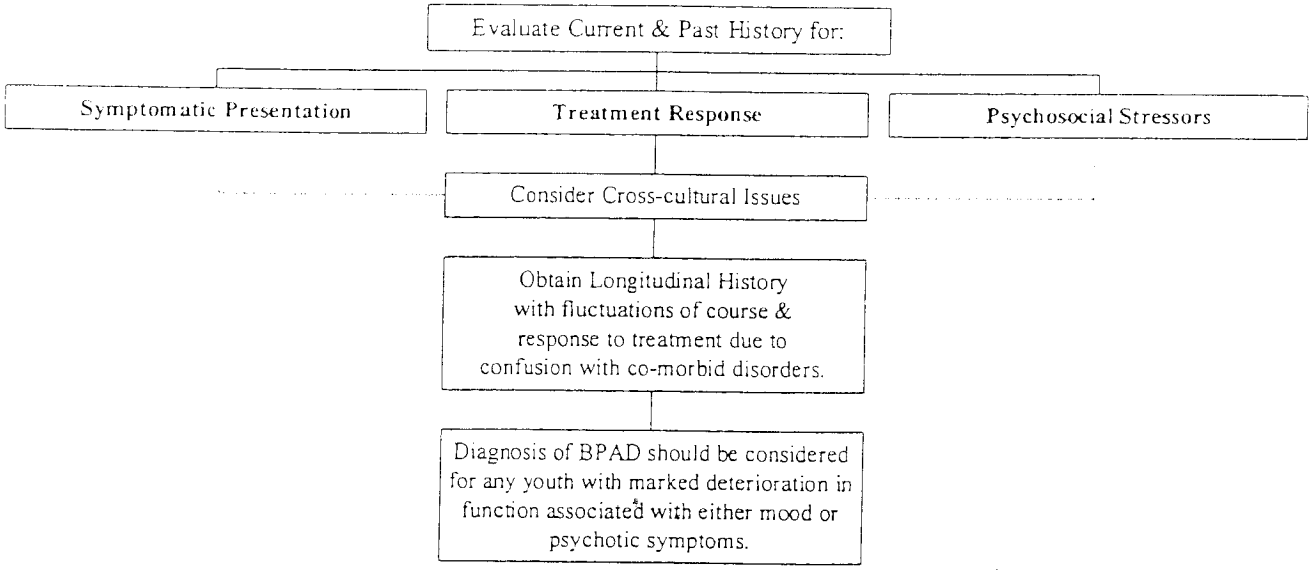
- *Neuropsychological functioning*
- *Substance-induced mood or symptoms*
- *Physical evaluation of the child to rule out organic conditions*

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

Developmental Issues



Diagnostic Issues



ECT

The use of ECT for persons under eighteen years of age requires strict adherence to procedural safeguards set forth in T.C.A. Title 33, Chapter 8, part 3. Indications and important considerations regarding the use of ECT in children are otherwise discussed fully in the complete AACAP practice Parameter, cited above. A careful reading of both the statute and the practice parameter is necessary to any consideration of this intervention.

Other Treatment Modalities to be considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with bipolar disorder, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least nine months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- for the service recipient
- for the family

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's bipolar disorder *should not* be used.)

Cognitive-behavioral therapy to address inappropriate or negative thought patterns and behaviors associated with the illness.

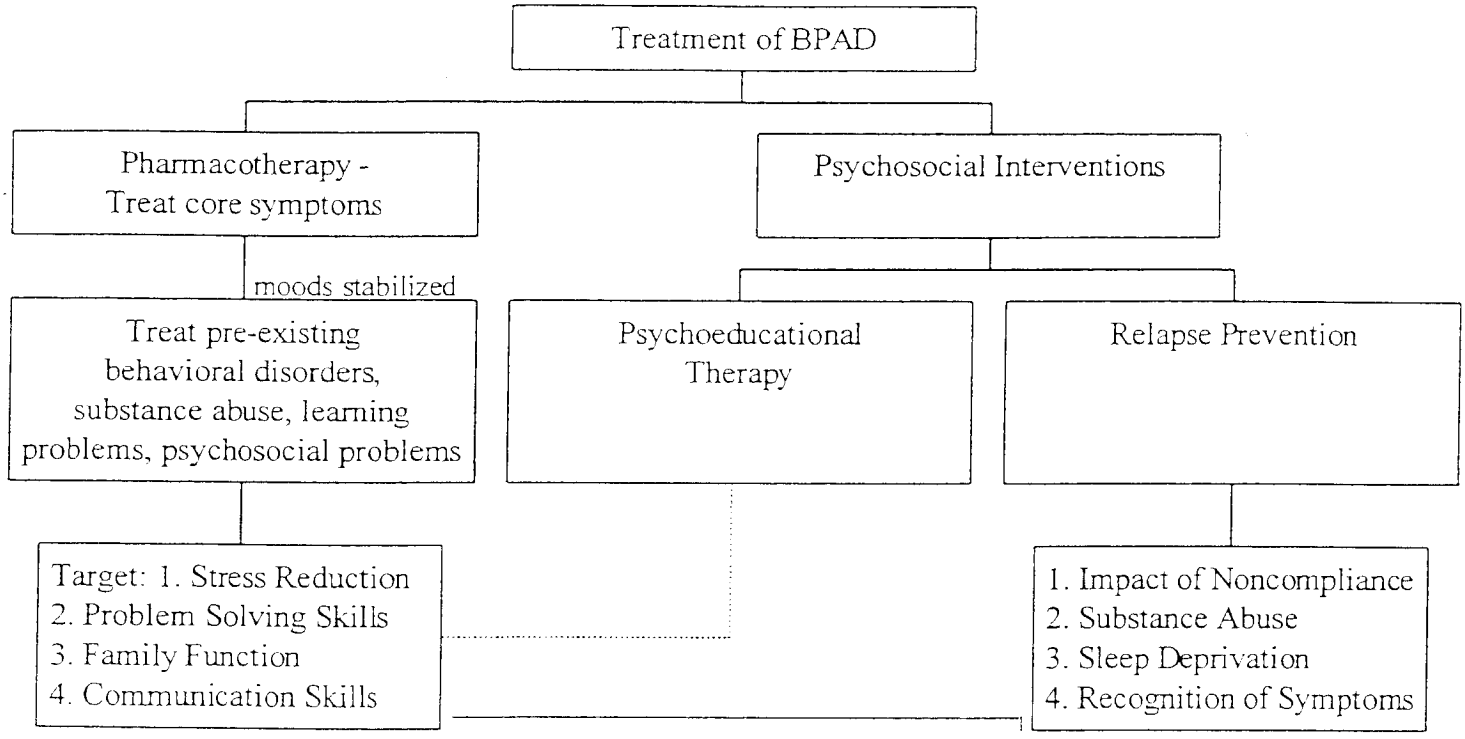
Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality.

Partial hospitalization or day treatment programs Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings.

Residential treatment

Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting, when less restrictive alternatives have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Treatment of BPAD



TDMHDD GUIDELINE

Evaluation and Treatment of Conduct Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with conduct disorder in primary care and behavioral treatment settings. Portions of this guideline are based on the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with conduct disorder.* J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):122S-139S
>
> Decision trees and essential outline materials were furnished by Martha Wike, Ph.D., Consulting Psychologist, Tennessee Department of Children's Services

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Treatment

Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of conduct disorder includes intervention in the family, school, and peer group. Typically, several of the following treatment modalities are used in conjunction in order to provide a comprehensive model. Wrap-around approaches, Multi-Systemic Therapy (MST) and Continuing Comprehensive Family Treatment (CCFT) are all noted as effective approaches to Conduct Disorder.

- Treat comorbid disorder

- *Family interventions* include parent guidance, skills training and family therapy.

→ Work on parenting strengths ...eliminate too harsh and too permissive approaches
→ Treat parental pathology

- *Individual and group psychotherapy* with adolescent or child. The technique of intervention should be adapted to child's age, processing style, and ability to engage in treatment.

→ Group therapy is important with adolescents
→ Individual therapy, alone, is ineffective

- *Psychosocial skill-building training.*

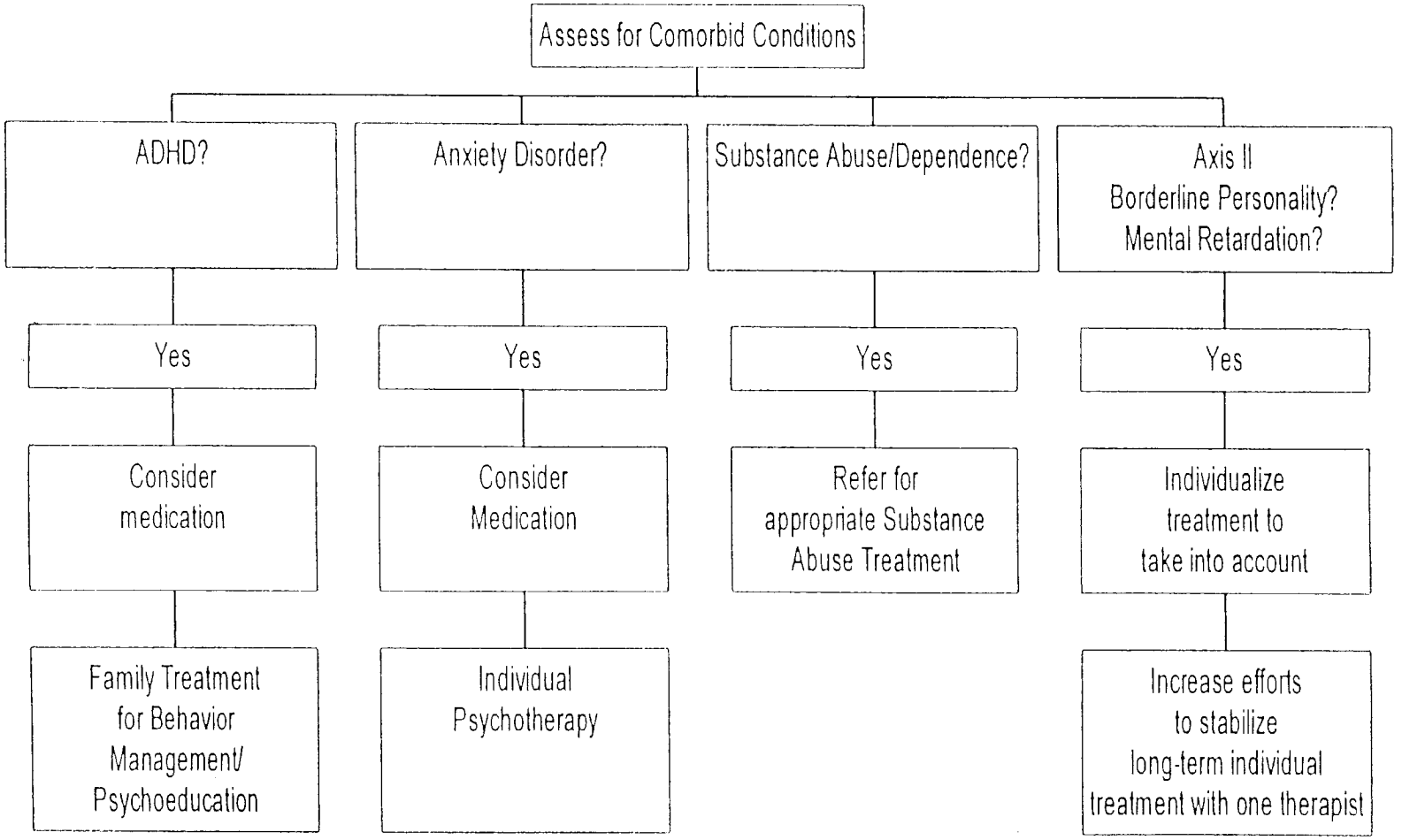
→ Child training to improve peer relationships
→ Child training to improve academic skills
→ Child training to improve compliance with demands from authority figures
→ Social skills building

- *Other psychosocial interventions* should be considered as indicated. Some interventions to consider are peer intervention, school intervention for appropriate placement, juvenile justice system intervention, social services, community resources, out-of-home placement, and job and independent-living skills training.

- *Psychopharmacology.* Medications are recommended only for treatment of target symptoms and comorbid disorders and are recommended only on the basis of clinical experience.

- *Level of care decision-making.* Level of care should be the least restrictive level of intervention that fulfills both the short and long-term needs of the service recipient.

Assessment


Assess for Comorbid Conditions
ADHD?
Anxiety Disorder?
Substance Abuse/Dependence?
Axis II
Borderline Personality?
Mental Retardation?
Yes
Yes
Yes
Yes
Consider
medication
Consider
Medication
Refer for
appropriate Substance
Abuse Treatment
Individualize
treatment to
take into account
Family Treatment
for Behavior
Management/
Psychoeducation
Individual
Psychotherapy
Increase efforts
to stabilize
long-term individual
treatment with one therapist

TDMHDD GUIDELINE

Depression in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with depressive disorders in primary care and behavioral treatment settings. These guidelines are adapted from:

> *Practice parameters for the assessment and treatment of children and adolescents with depressive disorders.* J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):63S-83S [231 references]

The user may wish to consult the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with depression and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inservice recipient mental health service providers to maintain treatment review committees for service recipients admitted to inservice recipient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1 Tennessee Code Annotated § 33-3-218 through 220

2 Tennessee Code Annotated § 33-6-107 et. seq.

Assessment

- Comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and collateral informants, such as teachers and social services personnel
- Evaluation performed by a clinician trained to consider how developmental and cultural factors impact the service recipient's clinical presentation
- Performance of a developmentally appropriate mental status examination (MSE), physical examination, laboratory tests

AND these symptoms:

• SOCIAL IMPAIRMENT OR IMPAIRMENT IN PERFORMANCE OF ACTIVITIES • UNRELATED TO SUBSTANCE ABUSE	• UNRELATED TO BEREAVEMENT • UNRELATED TO MEDICATION USE OR OTHER PSYCHIATRIC ILLNESS

Treatment

Treatment Planning

- Develop treatment plan appropriate to developmental stage of child or adolescent
- Provide services in the least restrictive environment that provides safety and effectiveness

Acute Treatment

- The choice of initial therapy depends on
  - Chronicity
  - Severity and number of prior episodes
  - Contextual issues
  - Previous response to treatment
  - Age of service recipient
  - Compliance with treatment
  - Service recipient's and family's motivation for treatment
- Pharmacotherapy alone usually is not sufficient.
- The high degree of comorbidity and the severity of psychosocial and academic consequences of depression suggest a multi-modal treatment approach.
- Because depression usually runs in families it is important to assess and treat other family members and those who live with the service recipient.

Service recipient and Family Education

The service recipient and caregivers should be taught about the disease and the treatment involved. Family education involves family members as informed partners in the treatment team, and helps them understand depression as an illness, identify and manage affect, address psychosocial deficits, and learn the importance of compliance with treatment. Participation by parents may help them identify their own depressive symptoms.

Psychotherapy

- *Cognitive-Behavioral Therapy (CBT)* is based on the premise that depressed service recipients have cognitive distortions in how they view themselves, the world, and the future; that these cognitive distortions contribute to their depression. CBT teaches service recipients to identify and counteract these distortions. Clinical studies found a high rate of relapse upon follow-up, suggesting the need for continuation treatment.

TDMHDD Guideline

Mental Retardation and Comorbid Disorders In Persons Under 22 Years of Age

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have mental disorders comorbid with mental retardation (MR). These guidelines are adapted from the following sources:

Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 Dec;38(12 Suppl):5S-31S [117 references]

Rush AJ, & Frances A,. eds. *The Expert Consensus Guideline Series: Treatment of Psychiatric and Behavioral Problems in Mental Retardation.* American Journal on Mental Retardation 2000;105:159-228.

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to twenty-one to twenty-two years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.

2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment Methods

Preferred methods of evaluation

Interview with family/caregivers
Medical history and physical examination
Medication and side effects evaluation
Direct observation of behavior
Functional behavioral assessment
Unstructured psychiatric diagnostic interview †

Also consider:

- Standardized rating scales (e.g. SCID, BDI)
- Biomedical evaluation, including family, pregnancy, perinatal, developmental, health, social, and educational history; physical and neurodevelopmental examination; and laboratory tests. Laboratory tests are usually indicated by the findings in the history and physical examination and may include chromosomal analysis (including fragile-X by DNA analysis); brain imaging (CT scan, MRI); EEG; urinary amino-acids; blood organic acids and lead level; appropriate biochemical tests for inborn errors of metabolism.
- Standardized testing (e.g. intelligence, neuropsychological, language) ††

† *first line for mild/moderate MR, but not severe/profound MR*

†† *in mild/moderate MR Only*

Recipient and Caregiver Interview

The recipient may present communication deficits or may otherwise be shy in regard to disclosure of relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the recipient lacks adequate communication skills. Attempts should be made to collect both anecdotal subjective information and more objective data, such as the Vineland Adaptive Scales, daily record keeping, or graphical data.

Comprehensive History Includes:

- Presenting symptoms/behaviors
- Assessment of functioning
- Treatment history
- Placements and supports
- Family/household dynamics
- Past evaluations

Recipient Interview:

- Ample time should be allotted for the service recipient interview. Sufficient time is needed to put the service recipient at ease.
- The interview should be adapted to the service recipient's communication skills.
- Clear and concrete language should be used.
- Reassurance and support should be provided.
- Leading and yes/no questions should be avoided.
- The interviewer should attempt to ensure that questions are understood.
- Mental status may be assessed from context of conversation, rather than by formal examination.
- Nonverbal expression and activity should be considered.

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with MR are now rarely if ever placed in residential institutions and separate schools. Adults with MR of all levels live in the community, in settings varying from their own apartments with supports as needed, to small shared living situations. They are employed in specialized settings or, increasingly, in the competitive job market. Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in MR (e.g., shunting in the case of hydrocephalus).
- Early intervention, education, and ancillary therapies (such as physical, occupational, language therapies, ***and behavior therapies***), family support, and other services, as needed.
- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome, treatment of seizures in persons with tuberous sclerosis, etc.
- Psychiatric treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric Treatment

The approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Modifications of treatment may be necessary, according to the individual's circumstance. Persons with Down Syndrome, e.g., may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents.

Medical, habilitative, and educational interventions should be coordinated within an overall treatment program. Medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and general medical treatment.

Medication decisions should be appropriate to the diagnosis of record, based upon specific indications, and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective.

Medication decisions need to be based upon adequate information, including medication history and consideration of the individual's complete, current regimen. Medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive function or exacerbation of ataxia. Risk vs. benefit needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

important, as well as help in obtaining educational supports to which the child is entitled under federal and local laws. Parents of adolescents and young adults need help in coming to terms with emergent sexuality, and in emotionally separating and preparing them to move to out-of-family living in the community.

Behavior Therapy is based upon scientific principles of behavior and uses a functional assessment to understand the variables that influence the behavior. Generally, to be effective, behavior therapy should be applied in all settings, and include an emphasis on increasing functional replacement skills, along with the reduction of the maladaptive behavior. This approach may include adjusting the environment to reduce physical and social conditions that seem to trigger maladaptive behaviors, and various specific techniques, such as systematic desensitization, progressive relaxation, anger management, assertiveness training, and training more effective social and interactional skills.

Conjoint Therapy with or without the child present may be used to address specific behavioral issues, and allows parents or caregivers to report their observations frankly. Parents or caregivers can be supported in their efforts at behavior management, which may otherwise tend to be transitory.

Treatment Follow-up

A common problem in the treatment of persons with MR is assessing its effectiveness, which may be viewed differently by various caregivers. Therefore, discrete treatment goals should be agreed upon by the clinician and caregivers, as well as target or "index" symptoms. Interdisciplinary collaboration of professionals and caregivers is essential. Various mental health clinicians might function in the team as direct care providers, team leaders, or consultants to other professionals. Among them, clinicians with medically and psychologically oriented training are often prepared to function as synthesizers of treatment modalities of various disciplines. Followup includes service recipient interview/observation and obtaining comprehensive interim information. If the service recipient is not experiencing improvement, the accuracy and completeness of the biopsychosocial diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

TDMHDD Guideline

Posttraumatic Stress Disorder (PTSD) in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have posttraumatic stress disorder. These guidelines are adapted from the following sources:

> *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorders*. J. Am. Acad. Child Adolsec. Psychiatry, 37:10 Supplement, October 1998
>
> Foa EB, Davidson JRT, and Frances A, eds. *The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder*. J Clin Psychiatry 1999;60 (Suppl 16).

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

A. To improve the quality and appropriateness of care for children/adolescents who are diagnosed as having posttraumatic stress syndrome.

B. To aid practitioners in the difficult task of assessment and in choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgment, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Obtain report of DSM-IV PTSD symptomatology in the child, with particular attention to developmental variations in clinical presentation.

Key symptoms Examples:

Reexperiencing the traumatic event	• Intrusive, distressing recollections of the event • Flashbacks (feeling as if the event were recurring while awake) • Nightmares (the event or other frightening images recur frequently in dreams) • Exaggerated emotional and physical reactions to triggers that remind the person of the event
Avoidance	• Of activities, places, thoughts, feelings, or conversations related to the trauma
Emotional numbing	• Loss of interest • Feeling detached from others • Restricted emotions
Increased arousal	• Difficulty sleeping • Irritability or outbursts of anger • Difficulty concentrating • Hypervigilance • Exaggerated startle response

Obtain report of any other significant current symptomatology. Give particular attention to disorders with high comorbidity with PTSD. (See Differential Diagnoses, below.)

Obtain report of whether the symptoms began prior to or following the identified traumatic event(s). (Note: This determination may be difficult if the stressor has been longstanding or ongoing; e.g., physical abuse).

Obtain report of the parents' and other significant others' emotional reaction to the traumatic event.

- Ascertain whether the parent or primary caregiver was directly exposed to the trauma (e.g., driving when a motor vehicle accident occurred) or experienced only vicarious exposure (e.g., child disclosed sexual abuse by a stranger)
- Obtain report of the presence of parental PTSD symptoms following the traumatic event
- Obtain perception of how much support has been available to the child since the event

Obtain report of child's past psychiatric history, including:

- Outpatient psychotherapy
- Partial or inpatient hospitalization
- Psychotropic medications
- Symptom course

Obtain medical history, including:

- Significant current or past medical problems, somatic complaints, surgery, significant injuries
- Current or past medications
- Current primary medical care provider

- Observe the child for the elements of the mental status exam and for behaviors that are found with PTSD.
  - → *Increased startle reaction or vigilance*
  - → *Traumatic reenactment (in younger children)*
  - → *Observable changes in affect or attention that may be indicative of reexperiencing phenomena*

Obtain information from school with appropriate release of information, if clinically indicated. (Note: Although school reports may be helpful with regard to confirming certain symptoms or posttraumatic changes, in many cases, school reports are not necessary to diagnose or treat PTSD in children.) Information obtained should include:

- Academic functioning with particular attention to changes since the traumatic event.
- Interactions with peers and involvement in non-academic activities, with particular attention to changes since the traumatic event.
- Temporal appearance of ADHD symptoms (i.e., present prior to or only after the traumatic event).

Determine the need for additional evaluations. (IQ testing, speech and language evaluation, pediatric evaluation), as needed and make appropriate referrals.

Consider the usefulness of standardized interviews and rating scales. Although semistructured interviews and parent- and child-rating scales of PTSD symptomatology may be helpful in following the clinical course of children with PTSD, the diagnosis of PTSD is based primarily upon the clinical interview. The use of standardized interviews and scales is not necessary to make this diagnosis.

- Semistructured interviews. The following semistructured interviews include PTSD sections; none has established psychometric properties for measuring DSM-IV PTSD symptoms in children:

K-SADS-PL	Diagnostic Interview Schedule
Structured Clinical Interview for DSM-IV	Clinician-Administered PTSD Scale for Children and Adolescents.

- Child- and parent-rating forms that may be clinically useful for following the course of PTSD symptoms in children:

PTSD Reaction Index	Trauma Symptom Checklist for Children
Checklist of Child Distress Symptoms Child and Parent Report Versions	Children's Impact of Traumatic Events Scale
Child PTSD Symptom Scale	Impact of Events Scale (Revised version for adolescents)

Psychological and Psychiatric Treatment

Formulate the treatment plan based on the clinical presentation of the child and to address both PTSD symptoms and other behavioral and emotional problems the child is experiencing.

The course of PTSD and its particular symptom pattern in different children is extremely variable. Short-term, long-term, or intermittent treatment may be required. Different levels of care (outpatient, partial or inpatient hospitalization) and modalities (individual, family, group, psychopharmacologic therapy) may be required for different children or for a given child at different points in the course of the disorder. Comprehensive treatment for PTSD is generally multimodal and may include any or all of the following components.

Treatment Strategies Include:

Psychoeducation Education of the child, parents, teachers, and/or significant others regarding the symptoms, clinical course, treatment options, and prognosis of childhood PTSD.

Individual therapy

- Trauma-focused therapy should include:
  - → Exploration and open discussion of the traumatic event; relaxation, desensitization/exposure techniques may be useful.
  - → Examination and correction of cognitive distortions in attributions about the traumatic event.
  - → Behavioral interventions to address inappropriate traumatic reenactment (e.g., sexually inappropriate behaviors following sexual abuse; self-injurious, aggressive, and other behavioral difficulties).
  - → Cognitive-behavioral techniques to help child gain control over intrusive reexperiencing symptoms.
- Insight-oriented, interpersonal, and psychodynamic therapeutic interventions may be appropriate for treating PTSD in some children.
- Therapy to address non-PTSD behavioral and emotional difficulties, in conjunction with trauma-focused interventions.

Family Therapy

Trauma-focused parental therapy should include:

- → Exploration and resolution of the emotional impact of the traumatic event on the parent.
- → Identification and correction of inaccurate parental attributions regarding the traumatic event (e.g., self-blame, blaming the child).
- → Identification and implementation of appropriate supportive parenting behaviors and parental reinforcement of therapeutic interventions (e.g., teaching parents to help the child use progressive relaxation techniques).
- → Parent training on management of inappropriate child behaviors.

- Traditional family therapy with all immediate family members for families with high conflict, harsh discipline, and/or when PTSD symptoms are present in several family members. However, family therapy generally should occur only after the child has

Sequencing Treatments when PTSD Presents with Psychiatric Comorbidity:

When a comorbid psychiatric disorder is present, the experts recommend treating PTSD with a combination of both psychotherapy and medication from the start. It is therefore vital that questions about comorbidity and substance use should be included in the evaluation of every service recipient with PTSD.

Comorbid condition	Recommended strategy
Depressive disorder	Combine psychotherapy and medication from the start
Bipolar disorder	Combine psychotherapy and medication from the start
Other anxiety disorders (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	Combine psychotherapy and medication from the start
Substance abuse or dependence	
Milder problems with substance abuse	Provide treatment for both substance abuse and PTSD simultaneously
More severe problems with substance	Treat substance abuse problems first *or* Provide treatment for both substance abuse and PTSD simultaneously

Level of Care During the Initial Phase of Treatment (First 3 Months or Until Stabilized):

During the initial stage of treatment, the experts recommend that psychotherapy should generally be delivered weekly in individual sessions of about 60 minutes duration. Weekly medication visits are recommended for the first month, with visits every other week thereafter. Recommendations for treatment intensity during the maintenance phase are given in Guideline 8. *(**bold italics** = treatment of choice)*

	Recommended	Also consider
Frequency of psychotherapy sessions	Weekly	Twice a week
Duration of psychotherapy sessions	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions	***Individual***	Combination of individual and group or family therapy
Frequency of medication visits	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

Preferred Psychotherapy Techniques for Different Target Symptoms

Three psychotherapy techniques—exposure therapy, cognitive therapy, and anxiety management—are considered to be the most useful in the treatment of PTSD. As shown in the table below, the experts make distinctions among the techniques depending on which specific type of symptom presentation is most prominent. Psychoeducation is recommended as a high second line option for all types of target symptoms, probably reflecting the experts' belief that it is important in the treatment of every service recipient with PTSD, but is not by itself sufficient. Note also that the experts recommend considering play therapy for certain types of target symptoms in children.

Most prominent symptom	Recommended techniques	Also consider
Intrusive thoughts	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Flashbacks	Exposure therapy*	• Anxiety management • Cognitive therapy • Psychoeducation
Trauma-related fears, panic, and avoidance	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Numbing/detachment from others/loss of interest	Cognitive therapy	• Psychoeducation • Exposure therapy
Irritability/angry outbursts	Cognitive therapy Anxiety management	• Psychoeducation • Exposure therapy
Guilt/shame	Cognitive therapy*	• Psychoeducation • Play therapy for children
General anxiety (hyperarousal, hypervigilance, startle)	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation • Play therapy for children
Sleep disturbance	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation
Difficulty concentrating	Anxiety management	• Cognitive therapy • Psychoeducation

* Treatment of choice

Selecting the Next Step:

Experts contributing to the Consensus Guideline on PTSD were asked to recommend the next step when service recipients with PTSD have had no response to the initial treatment. Their first line recommendations were the same for service recipients with acute and chronic PTSD as well as for service recipients who also have suicidal or aggressive tendencies. For service recipients receiving monotherapy (i.e., medication alone or psychotherapy alone), the experts offered two general treatment recommendations:

1. Add the type of treatment the service recipient has not yet received (i.e., add medication to psychotherapy or add psychotherapy to medication) *and/or*
2. Switch to a different psychotherapy technique or to a different medication.

Both of these strategies may be helpful, either separately or in combination. Clinicians should use their clinical judgment, based on the specific situation, in deciding whether to add a new treatment, switch to a different treatment, or do both.

Presentation	No response to psychotherapy alone	No response to medication alone	No response to combined psychotherapy and medication
Acute and chronic PTSD	Add medication *and/or* Switch to other psychotherapy technique(s)	Add psychotherapy *and/or* Switch to another medication	Switch to another medication *and/or* Switch to or add other psychotherapy technique(s)

Strategies for Further Psychotherapy:

For a service recipient who is not responding to one of the three preferred psychotherapy techniques, the experts recommend adding one or both of the other two techniques. Adequate psychoeducation should also always be provided.

If current psychotherapy technique is	Combine with	Also consider
Anxiety management	• Cognitive therapy • Exposure therapy	• Psychoeducation
Cognitive therapy	• Anxiety management • Exposure therapy	• Psychoeducation
Exposure therapy	• Anxiety management • Cognitive therapy	• Psychoeducation

Recommended Psychological Treatments include:

- Anxiety Management
- Cognitive Therapy
- Exposure Therapy

When to Refer for Specialized Psychiatric Care

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are treating PTSD, the particular needs and preferences of the service recipient, and the availability of other services. However, referral for specialized care is often necessary in the following situations:

- Service recipient has persistent impairing PTSD symptoms that have not responded to at least one systematic medication trial, adequate in dose and duration.
- Service recipient has suicidal thoughts/behavior.
- Service recipient has had persistent problems with medication side effects.
- Service recipient has other serious psychiatric problems (e.g., depression, anxiety) that are not improving with treatment.
- Service recipient has substance abuse problems.
- Service recipient is experiencing other life stressors and/or has limited social support.

TDMHDD Guideline

Schizophrenia in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with schizophrenic symptoms in primary care and behavioral treatment settings. These guidelines are adapted from the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with schizophrenia.* J Am Acad Child Adolesc Psychiatry 1994 Jun;33(5):616-35 [90 references]
>
> *The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations*. 1998. Agency for Healthcare Quality and Research, Rockville, MD. http://www.ahrq.gov/clinic/schzrec.htm

The user may wish to refer to the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with schizophrenia and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Evaluation

Complete diagnostic assessment including a neurologic and thorough psychiatric evaluation, school information, and history is needed, and specifically should include the following:

- Premorbid History (prenatal, developmental, personality, highest LOF)
- History of present illness (DSM-IV target symptoms; course of illness, including onset, cyclical patterns, precipitating stressors; associated or compounding symptoms, especially mood disturbances, substance abuse, and organic factors
- Physical evaluation
- Family history (environment, interactions, coping styles, resources, strengths; history of psychiatric and neurological conditions, and substance abuse)
- School functioning
- Suspected skills deficits

Rule out other disorders and determine if necessary to hospitalize.

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

Treatment Overview

Multimodal psychotherapeutic interventions include:

1) medication management
2) periodic diagnostic reassessments to ensure accuracy of diagnosis
3) appropriate psychotherapy
4) psychoeducational services for the service recipient
5) supportive services for the family
6) educational and vocational services
7) residential services when indicated

Medication Therapy

Acute phase

Before initiating antipsychotic therapy, a thorough psychiatric evaluation is needed, which should include documentation of the psychotic symptoms targeted for the therapy. Preexisting abnormal movements should also be noted. Informed consent is needed from the parent and adolescent service recipients, while consent, when possible, should be obtained from preadolescents.

The choice of antipsychotic medication should be made based on the agent's relative potency, spectrum of side effects, and history of medication response in the service recipient and his or her family. Side effects that may occur with all antipsychotics (except clozapine) include extrapyramidal symptoms, anticholinergic symptoms, withdrawal dyskinesia, tardive dyskinesia, and neuroleptic malignant syndrome. There are also side effects specific to a particular agent, such as lenticular stippling with thioridazine, that need to be monitored when the agent is used.

When using antipsychotics, antiparkinsonian agents may be needed for the treatment of extrapyramidal side effects. Prophylactic use of antiparkinsonian agents should be

impairment in the service recipient's ability to maintain basic self-care, and the availability of supportive services in the community.

Service recipients who do not respond to antipsychotics

Before it is decided that the service recipient is a non-responder, the service recipient must receive at least two adequate trials of different antipsychotic agents.

In adults, there are reports of successfully augmenting antipsychotic therapy with lithium, anticonvulsants, benzodiazepines, and fluoxetine. However, these are yet unproven and have not been studied in children and adolescents.

There are reports of clozapine being used successfully for adolescents with schizophrenia, however, in the United States, there is little experience with its use in service recipients younger than sixteen years of age. If it is to be used, close monitoring for potential seizures, agranulocytosis (with periodic blood cell counts), and weight gain is necessary.

Adjunctive pharmacotherapies should be considered in service recipients who experience persistent and clinically significant associated symptoms of anxiety, depression, or hostility, despite an adequate reduction in positive symptoms with antipsychotic therapy.

Other Treatment Modalities to be Considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with schizophrenia, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least 9 months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- **for the service recipient**, includes cognitive-behavioral strategies, such as social skills and problem-solving skills, and ongoing education about the illness, medication effects, and basic life skills training

- **for the family** promotes understanding of the illness, treatment options, and prognosis and development of strategies to cope with the symptoms of the service recipient

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's schizophrenic disorder *should not* be used)

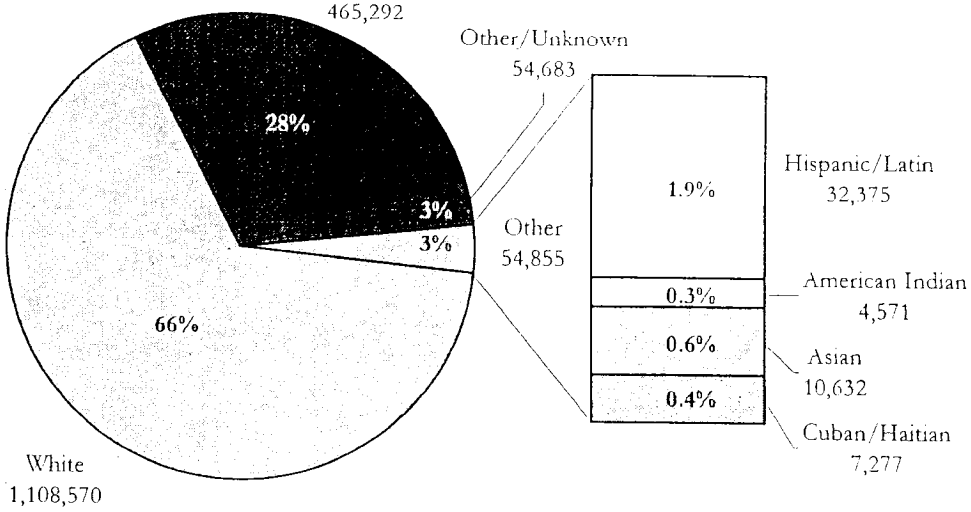
PROGRESS REPORT

ON THE TENNCARE PARTNERS PROGRAM: CHILDREN & YOUTH, FISCAL YEAR 2002

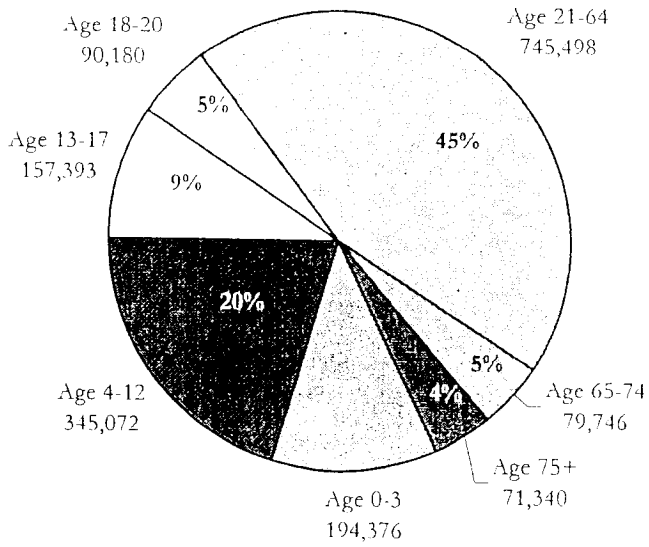
State of Tennessee
Bureau of TennCare and
Department of Mental Health and Developmental Disabilities
Office of Managed Care
Cordell Hull Building - 5th Floor
Nashville, TN 37243

Profile of Total TennCare Eligibles: FY 2002 (N=1,683,609)*

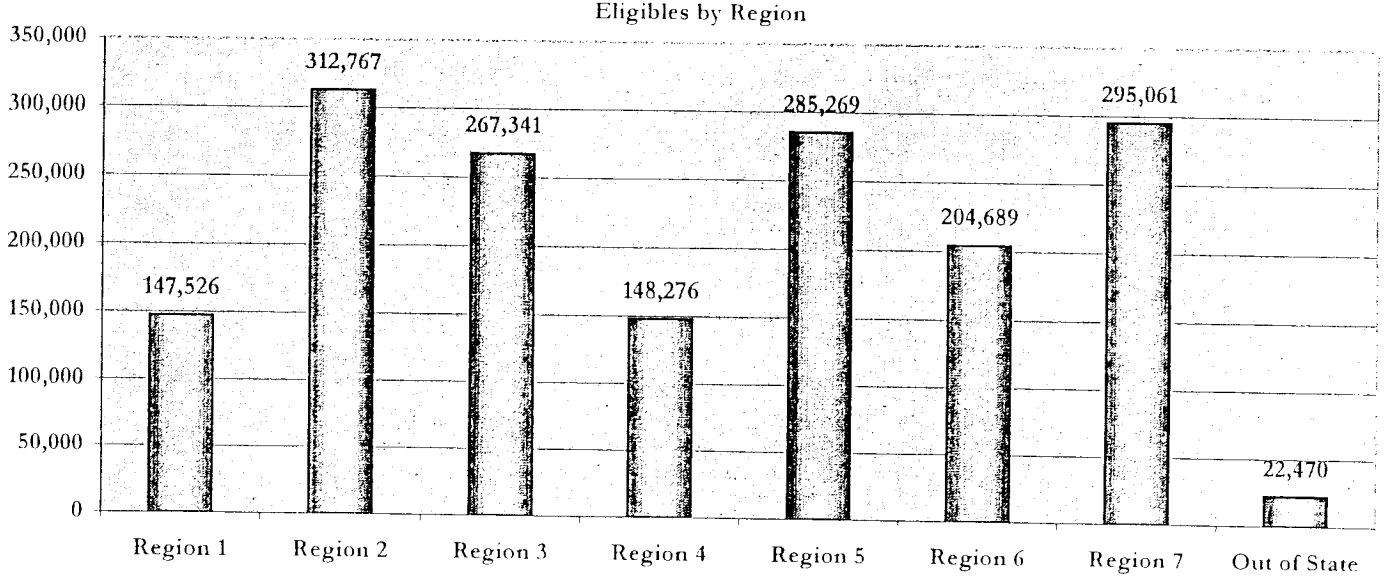
Eligibles by Race



Eligibles by Age Group



Eligibles by Region



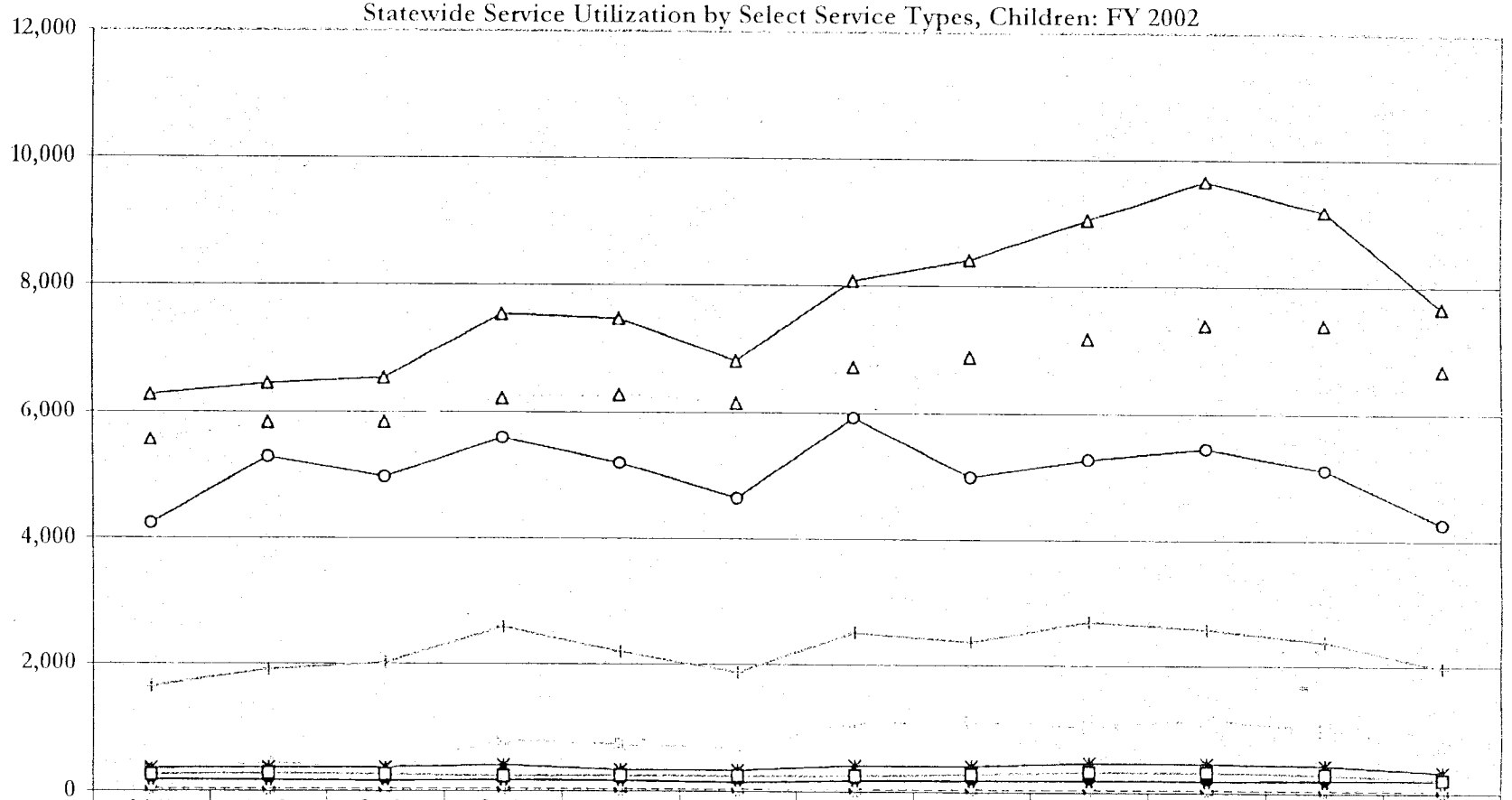
Total TennCare Eligibles include all individuals eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

* The sum of the eligibles in these charts do not include 209 eligibles of unknown race, 210 of unknown region, and 4 of unknown age that are included in the total (N).

Statewide Service Utilization by Select Service Types, Children: FY 2002

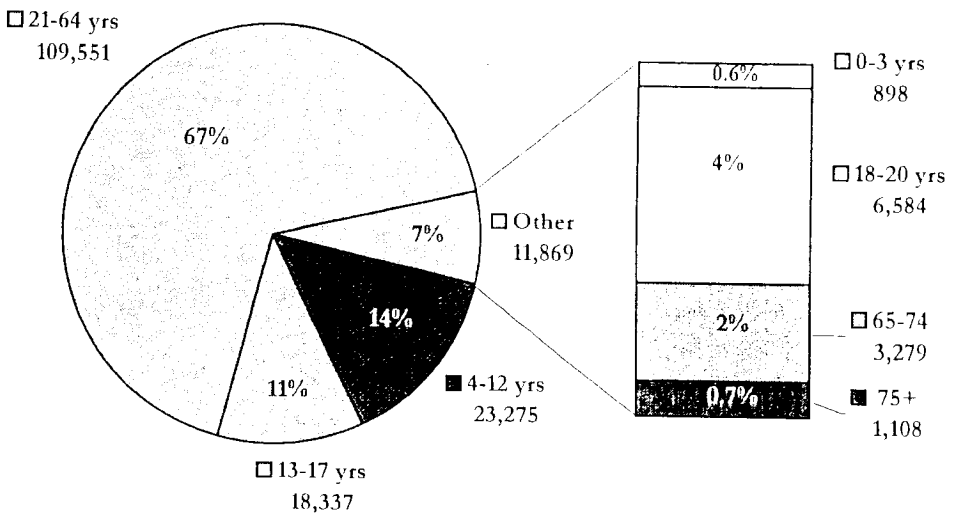
Children are defined as enrollees under age 18 as of the date of the service received.

Counts presented in the table reflect the number of unduplicated enrollees who received each service type for each month. A given enrollee is represented only once in each cell, but may be included in multuple months and service types.



	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02
24 Hr. Residential Treatment	189	179	166	180	173	149	182	189	197	192	204	211
Assessment	337	452	348	823	741	697	1,088	1,117	1,034	1,147	1,000	769
Case Management	5,559	5,839	5,843	6,219	6,275	6,152	6,721	6,881	7,177	7,391	7,388	6,681
Crisis Respite	10	8	2	2	6	1	2	1	-	2	1	3
Crisis Services	365	376	379	414	339	335	418	412	471	459	434	336
Day Treatment	33	28	31	34	21	20	18	39	36	38	36	15
EPSDT	1,647	1,911	2,019	2,592	2,195	1,870	2,514	2,372	2,700	2,578	2,383	1,971
Medication Management	4,238	5,288	4,968	5,593	5,195	4,639	5,923	4,986	5,273	5,444	5,108	4,263
Outpatient Therapy Services	6,273	6,449	6,536	7,539	7,469	6,806	8,071	8,409	9,052	9,659	9,184	7,659
Partial Hospitalization	35	43	43	44	33	32	50	50	51	48	38	24
Psychiatric Hospitalization	267	283	265	241	253	246	257	283	328	328	296	216
SA Inpatient	19	19	5	13	10	10	13	13	12	18	7	9
SA Outpatient	4	3	1	6	3	5	5	1	-	1	-	1
Transportation	552	599	580	653	623	584	709	718	782	789	693	622

Total Unduplicated Persons Served in FY 2002 by Age Group (N=163,110)*

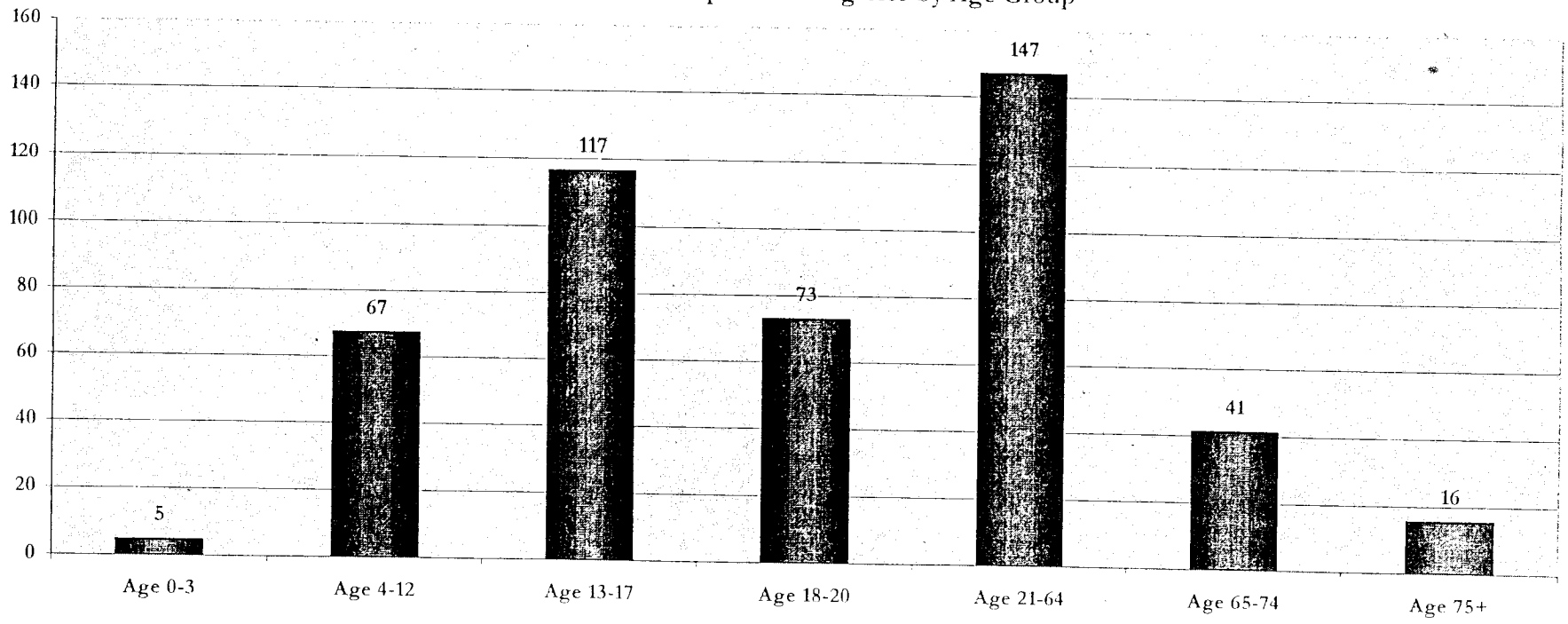


* The sum of the persons served in this chart does not include 78 consumers of unknown age that are included in the total (N).

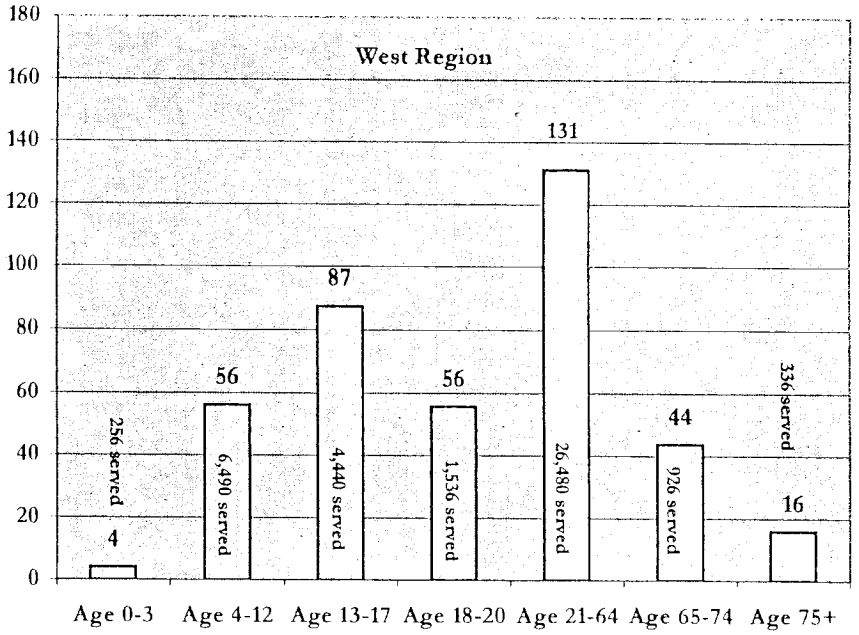
Unduplicated persons served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

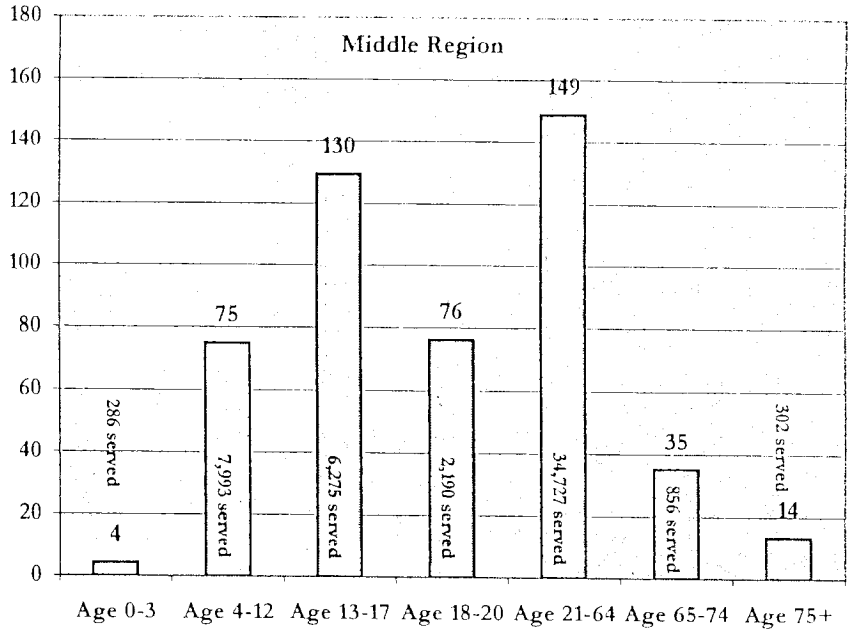
Rates are determined by dividing the number of persons served in each age group by the number of eligible enrollees in each group and multiplying by 1000.

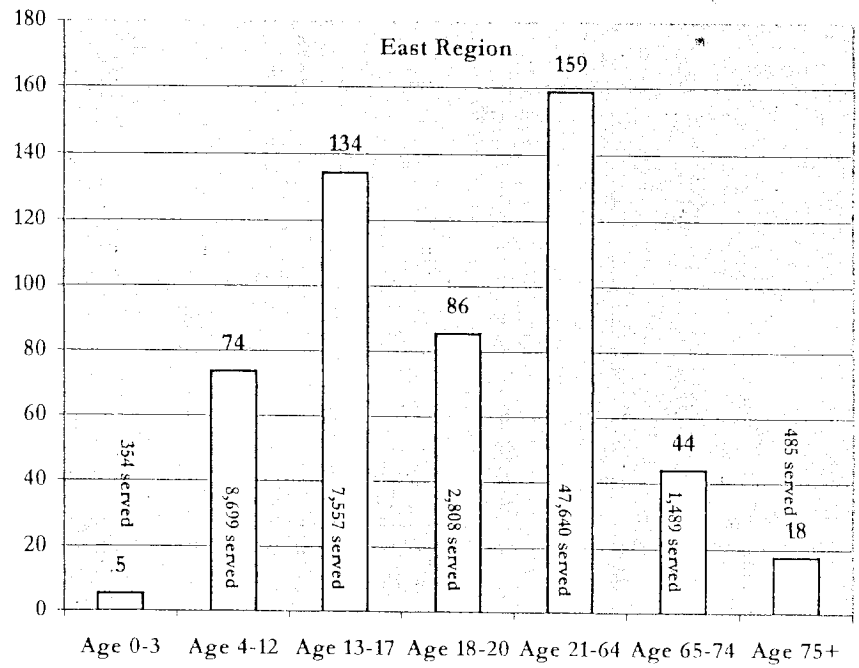
Rate of Persons Served per 1000 Eligibles by Age Group



Rate of Total Persons Served per 1000 Eligibles and Number of Persons Served, TennCare Grand Regions by Age Group: FY 2002







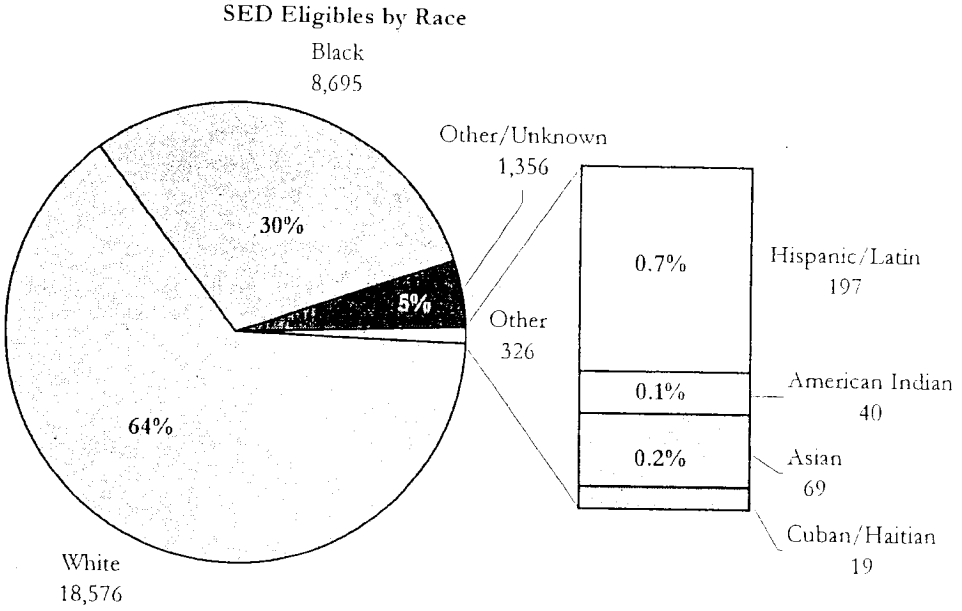
Rates are determined by dividing the number of persons served in each age group in each region by the number of TennCare eligible enrollees in each group and multiplying by 1000.

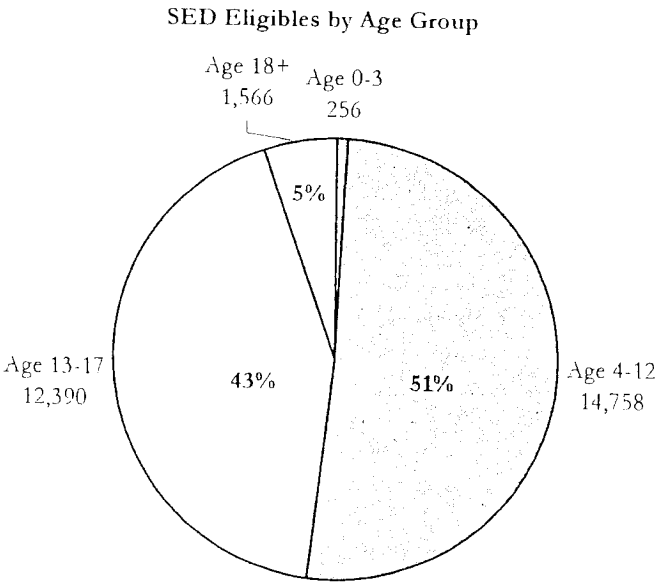
Persons served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is counted only once, regardless of the number of services received.

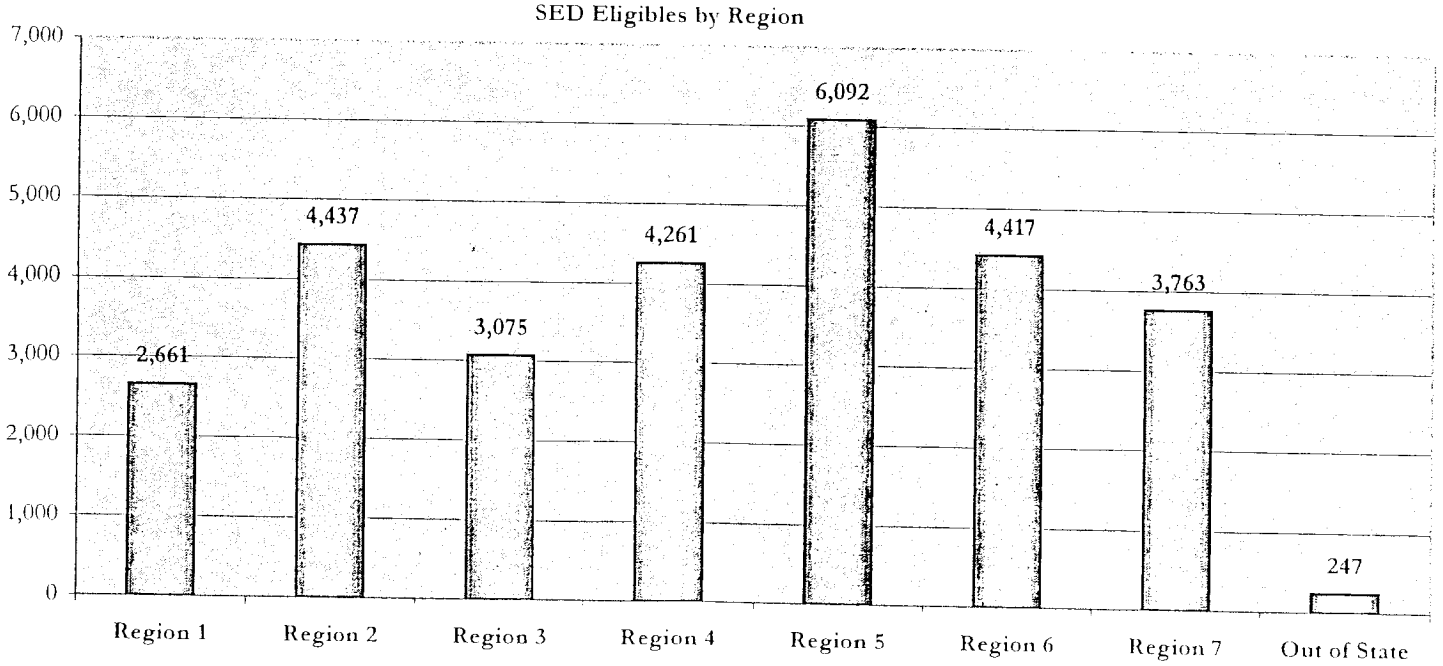
TennCare eligibles include all individuals eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

Tables reflect rates in the three TennCare Grand Regions. Not included are an additional 22,470 eligibles and 1,247 persons served outside of Tennessee.

Profile of SED TennCare Eligibles: FY 2002 (N=28,970)*



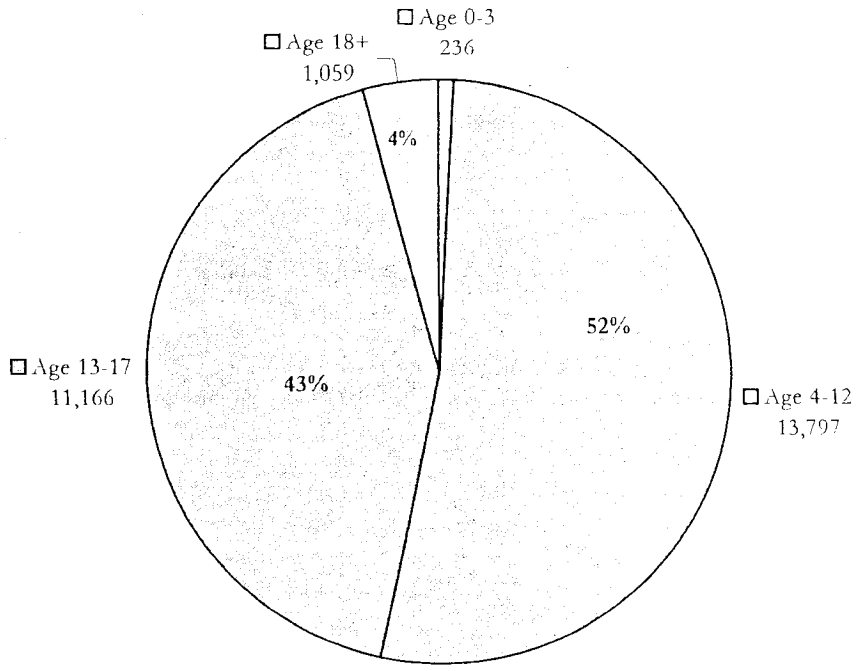




The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year. SED eligibles include all SED persons eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

The sum of the eligibles in these charts do not include 17 SED eligibles of unknown race and region that are included in the total (N).

Unduplicated SED Population Served in FY 2002 by Age (N=26,263)*



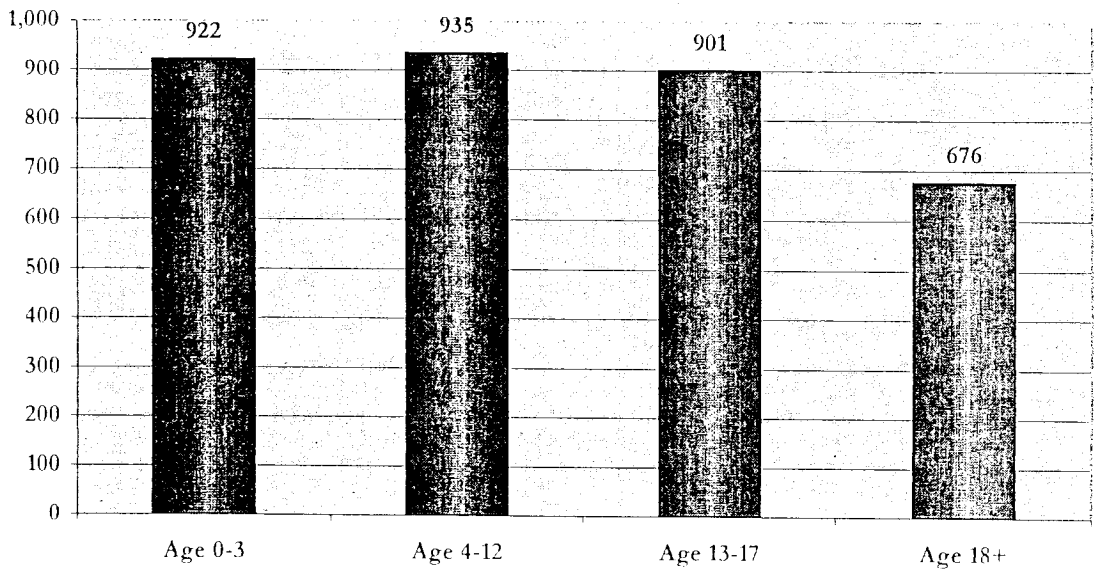
* The sum of the consumers served in this chart does not include 5 SED consumers of unknown age that are included in the total (N).

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

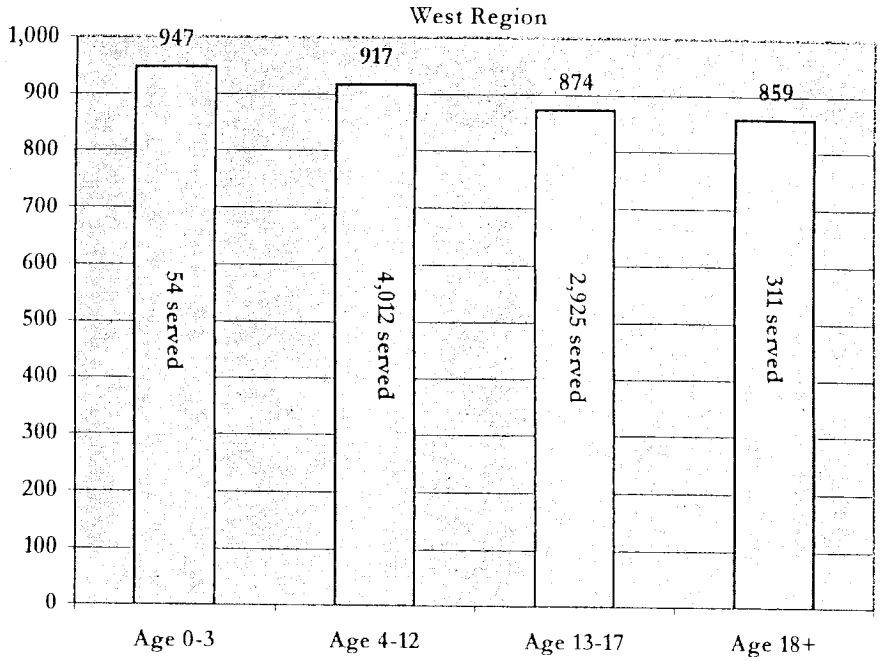
Unduplicated SED served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

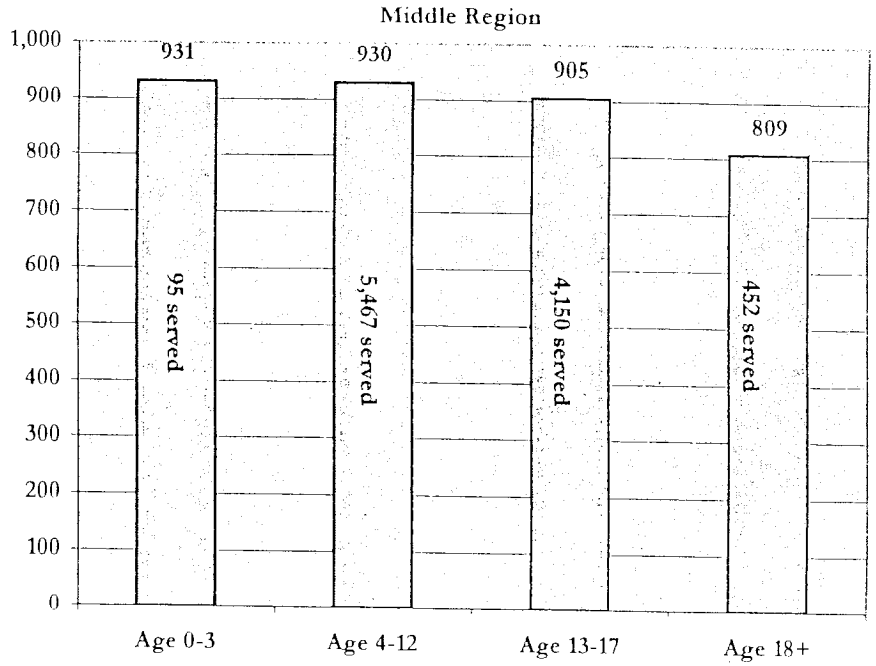
Rates are determined by dividing the number of SED persons served in each age group by the number of eligible SED enrollees in each group and multiplying by 1000.

Rate of SED Served per 1000 SED Eligibles



Rate of SED Served per 1000 SED Eligibles and Number of SED Served, TennCare Grand Regions by Age Group: FY 2002





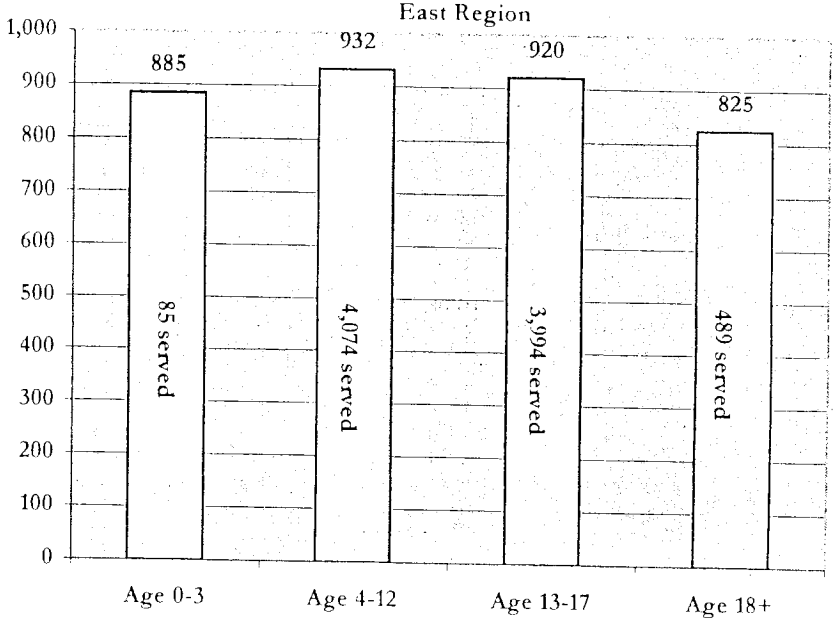
The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

Rates per 1000 are determined by dividing the number of SED persons served in each age group by the number of eligible SED enrollees in each group and multiplying by 1000.

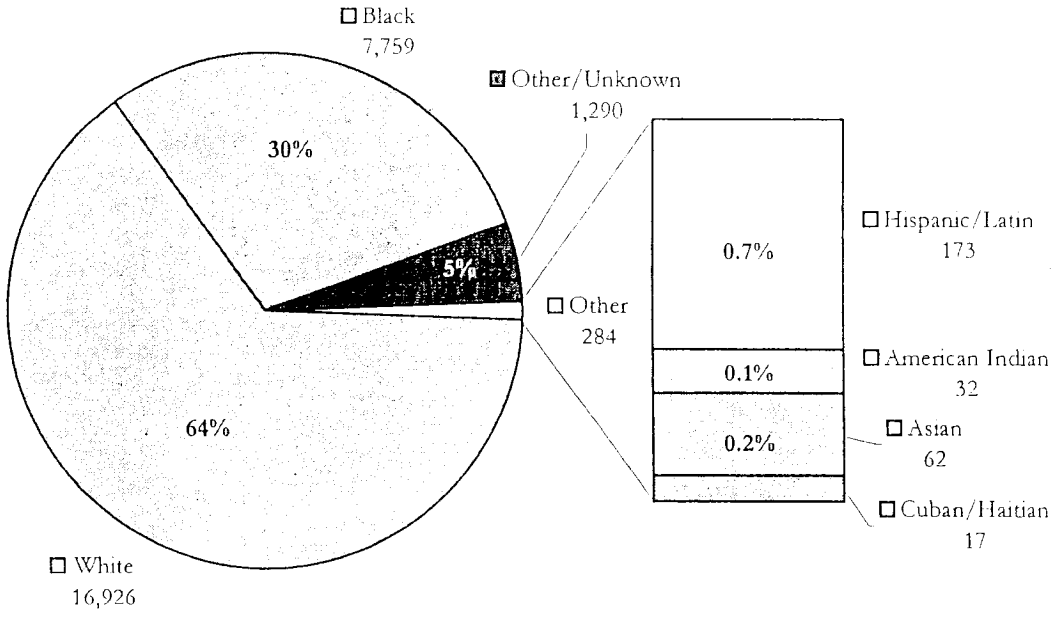
SED persons served refers to the number of unique SED enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is counted only once, regardless of the number of services received.

SED eligibles include all SED persons eligible to receive services through the Partners program for some period of time between 7/1/01 and 6/30/02, regardless of length of eligibility period.

Tables reflect rates in the three TennCare Grand Regions. Not included are an additional 247 SED eligibles and 155 SED served outside of Tennessee.



Unduplicated SED Population Served in FY 2002 by Race (N=26,263)*



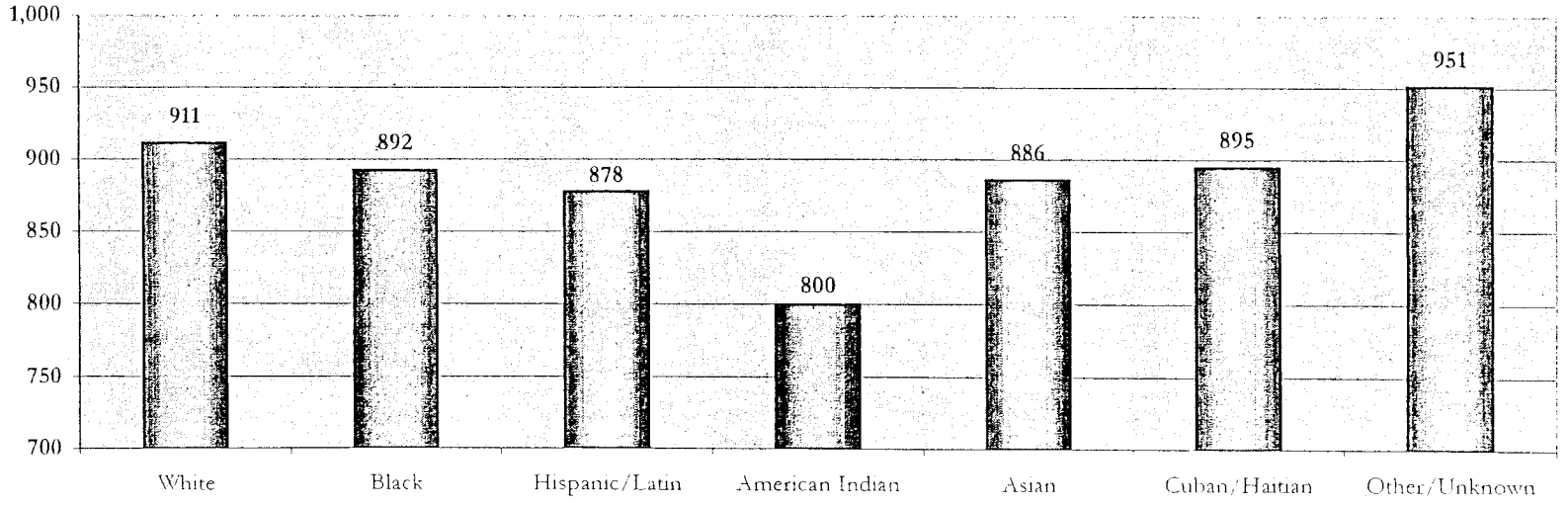
* The sum of the consumers served in this chart does not include 4 SED consumers of unknown race that are included in the total (N).

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service.

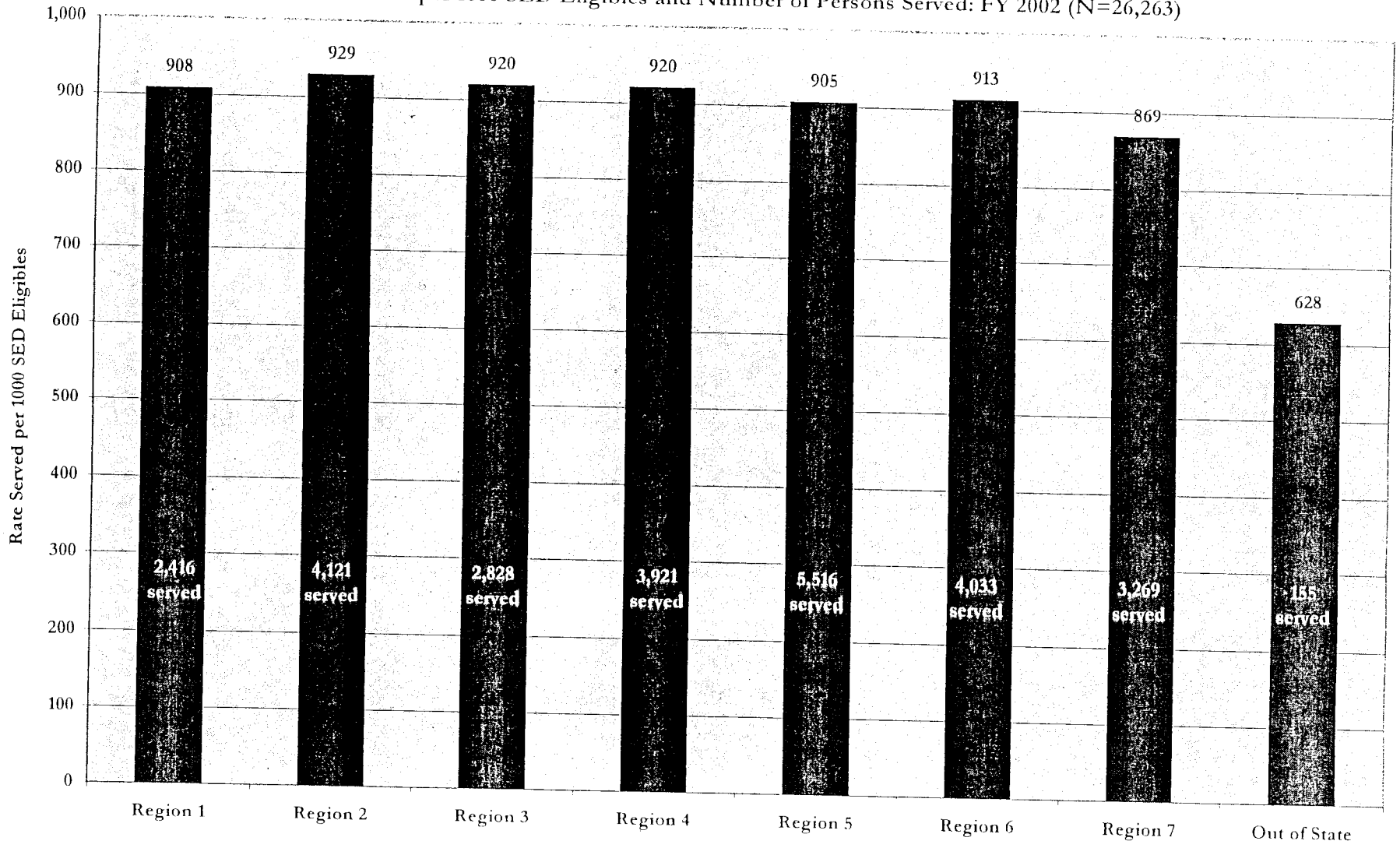
Unduplicated SED served refers to the number of unique enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received.

Rates are determined by dividing the number of SED persons served in each racial group by the number of eligible SED enrollees in each group and multiplying by 1000.

Rate of SED Served per 1000 SED Eligibles



Rate of SED Served per 1000 SED Eligibles and Number of Persons Served: FY 2002 (N=26,263)



* The sum of the consumers served in this chart does not include 4 consumers of unknown region that are included in the total (N).

SED served refers to the number of unique SED enrollees who received services through the Partners program 7/1/01 to 6/30/02. Each individual is represented only once, regardless of the number of services received. The SED population is defined as all Severely Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

Rates are determined by dividing the number of persons served in each region by the number of eligible enrollees in each region and multiplying by 1000.

SED Served in FY 2002 by Select Types of Service, by Sex and Race

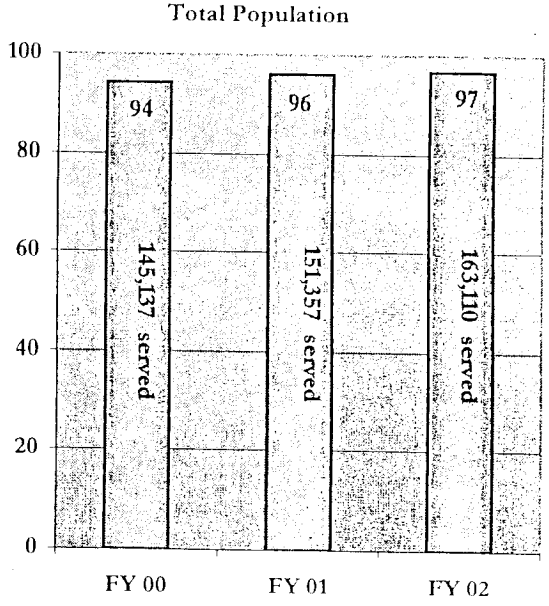
Service	Male (N=16,303)		Female (N=9,956)		White (N=16,926)		Black (N=7,759)		Other Races (N=1,578)		Total SED (N=26,263)	
	Unduplicated consumers	% of Males Served	Unduplicated consumers	% of Females Served	Unduplicated consumers	% of Whites Served	Unduplicated consumers	% of Blacks Served	Unduplicated consumers	% of Other Races Served	Unduplicated consumers	% of Total Served
24 Hr. Residential Treatment	337	2.1%	112	1.1%	332	2.0%	80	1.0%	37	2.3%	449	1.7%
Assessment	3,617	22.2%	2,190	22.0%	3,750	22.2%	1,711	22.1%	346	21.9%	5,807	22.1%
Case Management	8,511	52.2%	4,837	48.6%	7,591	44.8%	4,815	62.1%	942	59.7%	13,348	50.8%
Crisis Respite	19	0.1%	27	0.3%	35	0.2%	10	0.1%	1	0.1%	46	0.2%
Crisis Services	1,698	10.4%	1,355	13.6%	2,055	12.1%	835	10.8%	163	10.3%	3,053	11.6%
Day Treatment	108	0.7%	54	0.5%	142	0.8%	18	0.2%	2	0.1%	162	0.6%
EPSDT	8,513	52.2%	5,682	57.1%	9,605	56.7%	3,863	49.8%	727	46.1%	14,195	54.0%
Medication Management	9,419	57.8%	4,839	48.6%	8,848	52.3%	4,309	55.5%	1,101	69.8%	14,258	54.3%
Outpatient Therapy Services	10,487	64.3%	7,023	70.5%	11,588	68.5%	4,936	63.6%	986	62.5%	17,510	66.7%
Partial Hospitalization	171	1.0%	117	1.2%	196	1.2%	67	0.9%	25	1.6%	288	1.1%
Psychiatric Hospitalization	1,301	8.0%	991	10.0%	1,621	9.6%	533	6.9%	138	8.7%	2,292	8.7%
SA Inpatient	57	0.3%	28	0.3%	76	0.4%	5	0.1%	4	0.3%	85	0.3%
Transportation	1,539	9.4%	892	9.0%	1,159	6.8%	1,068	13.8%	204	12.9%	2,431	9.3%

SED served refers to the number of unique enrollees who received each selected service type 7/1/01 to 6/30/02. The table presents both the number of unduplicated SED consumers who received each type of service and the percentage of total SED persons served (N) for each category. For example, of the total SED males served (16,303), 3,617 (or 22.2% of the total SED males served) received assessment services. Of the SED females served, 2,190 received this service, or 22.0% of the 9,956 SED females served.

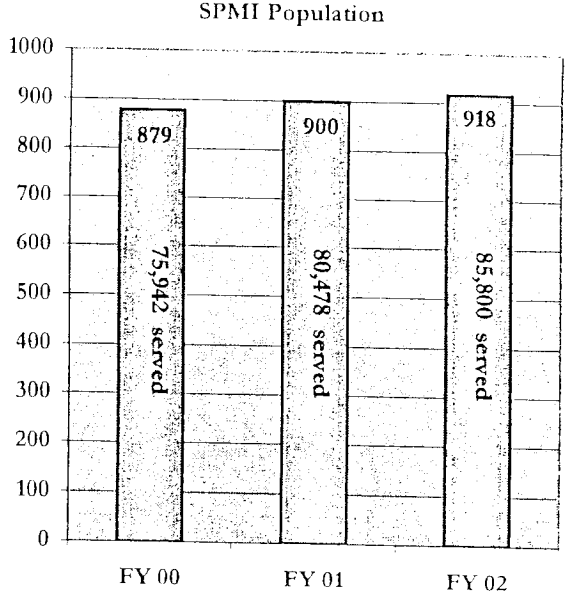
The sum of the consumers of each service type does not equal the total number of persons served (N) and the sum of percentages does not equal 100%, because a given enrollee may be represented in multiple service types.

The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

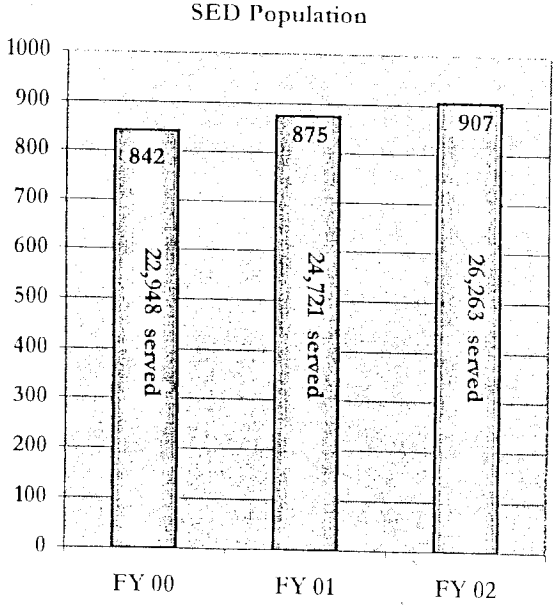
Rate of Persons Served per 1000 Eligibles: FY 2000, FY 2001, FY 2002



Rates for total population, SPMI, and SED are determined by dividing the number of persons served in each group by the number of eligible enrollees in each group and multiplying by 1000.



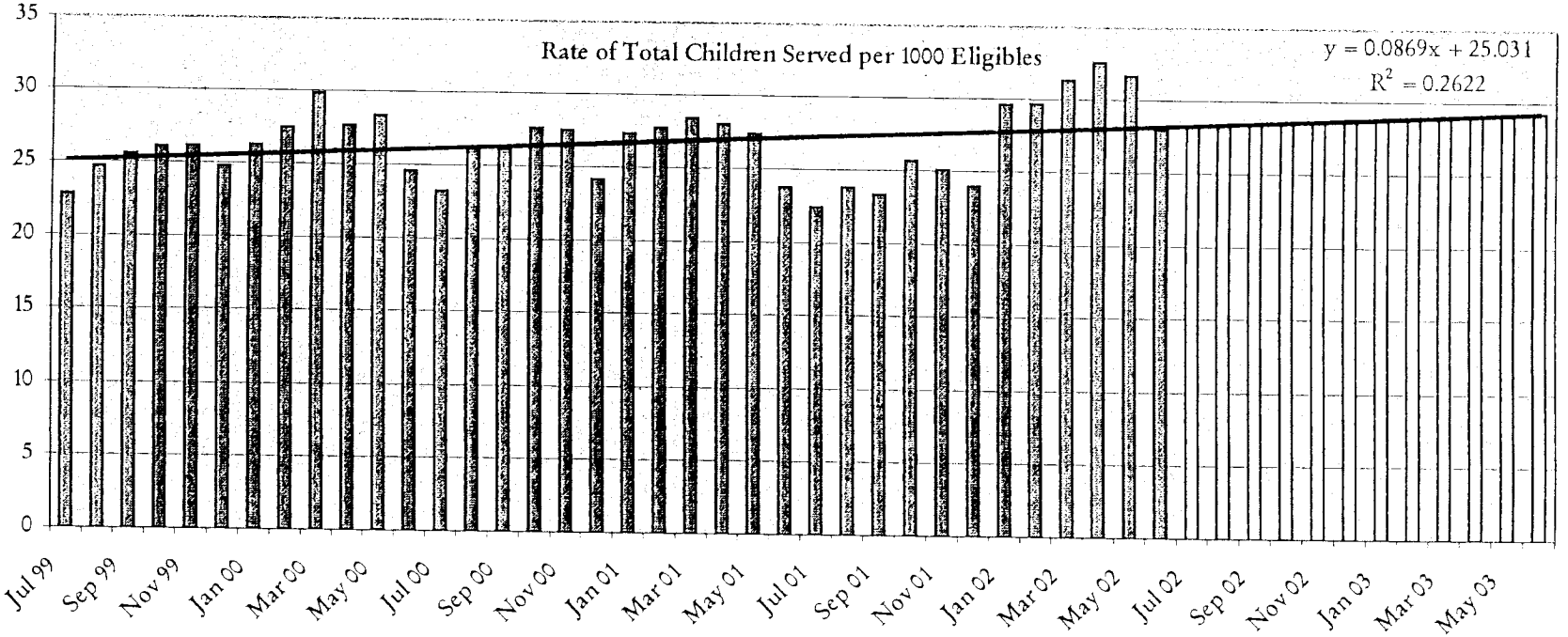
The SPMI population is defined as all Severely or Persistently Mentally Ill adults (a current CRG 1, CRG 2, or CRG 3 assessment). A current assessment is defined as within one year of the date of service.

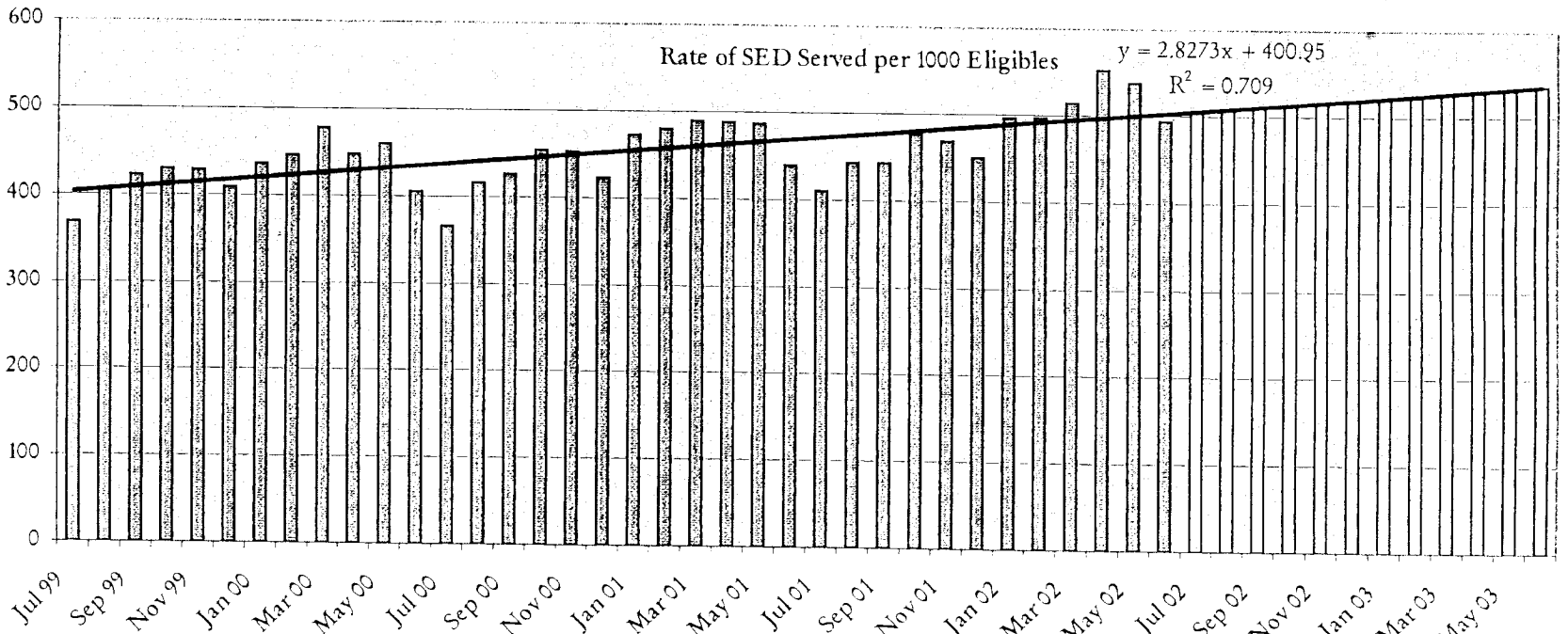


The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service received.

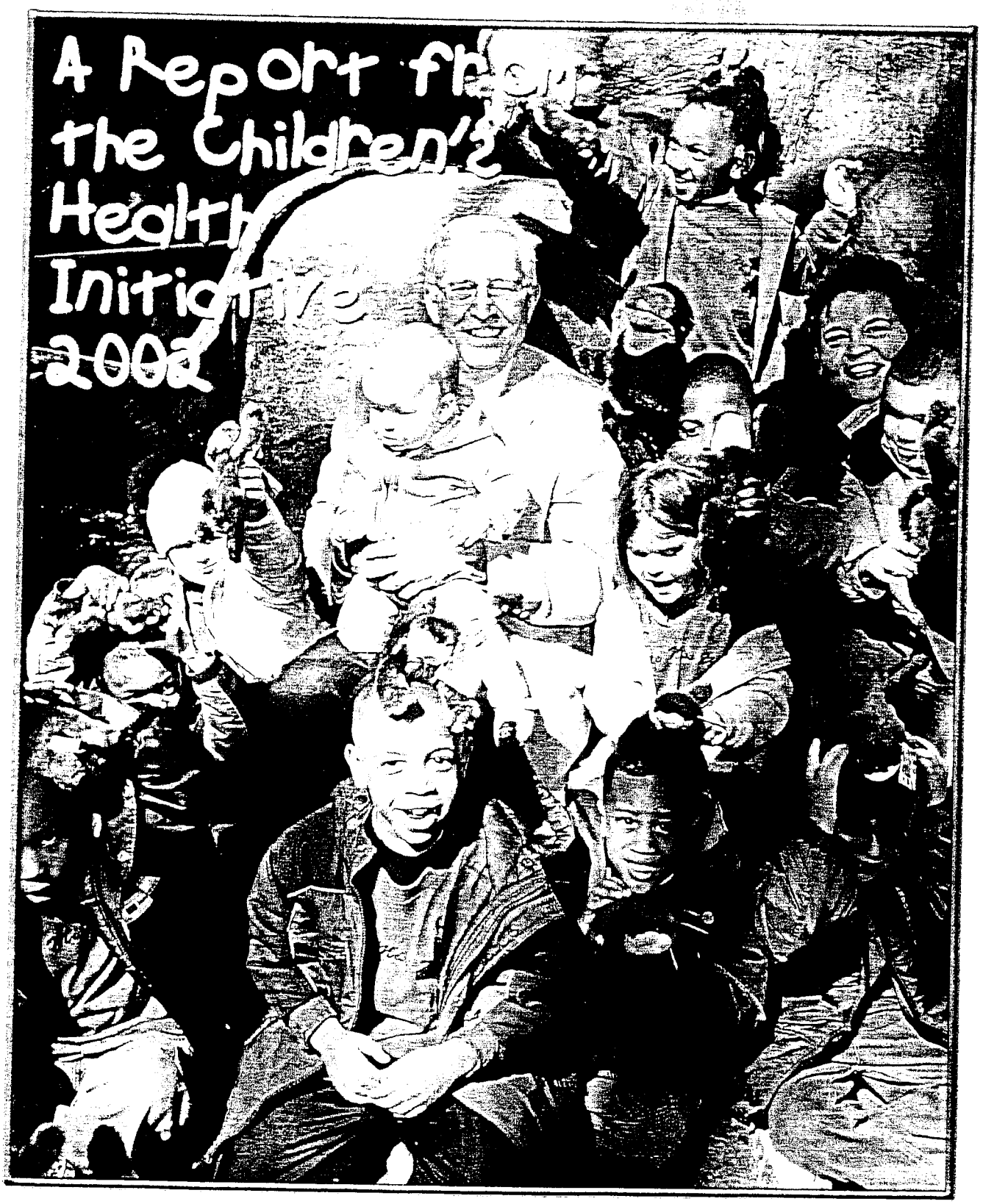
Children are defined as all persons under the age of 18. The SED population is defined as all Seriously Emotionally Disturbed children and youth (a current TPG 2 assessment). A current assessment is defined as within one year of the date of service.

Rates per 1000 are determined by dividing the number of children or SED persons served in each month by the number of eligible children or SED enrollees in each month and multiplying by 1000.





Tennessee Caring for Kids



small, these collective efforts are making a real difference and illustrate what can be done by breaking down barriers and working together on behalf of Tennessee's children.

This report documents the variety of activities and services that have resulted from these collaborative efforts. In the report, you will find information on the various workgroups' targeted efforts to increase preventive screenings for all TennCare children, plans to serve our dually diagnosed children with mental retardation and behavioral health needs, testimonials illustrating our commitment to ensure that state custody is not the only option for parents to receive services for their children, a report to the community on the significant improvements in dental care for our TennCare children, and many more topics.

I hope that you enjoy reading this important report, and that by reflecting on what has been accomplished, together we can see future possibilities for all of us to work together to improve services to Tennessee's most vulnerable children.

Special thanks is given to the Commissioners' EPSDT Task Force, the Children with Special Health Needs Steering Panel, and the TennCare and Children Workgroup. Without the hard work and leadership of these individuals and to many more dedicated and committed individuals, the outcomes highlighted in this report would not be possible.

Commissioners' EPSDT Task Force

Pictured from left: **Page Walley, Ph.D.**, Commissioner, Department of Children's Services; **Natasha Metcalf, J.D.**, Commissioner, Department of Human Services; **Manny Martins**, Deputy Commissioner, Bureau of TennCare; **Fredia Wadley, M.D.**, Commissioner, Department of Health; **Richard Kellogg**, Deputy Commissioner, Division of Mental Retardation Services; **Joe McLaughlin, Ph.D., Chair**, Director, Children's Health Initiative; **John Tighe**, Deputy Commissioner, Deputy to the Governor for Health Policy. *Not pictured:* **Elisabeth Rukeyser**, Commissioner, Department of Mental Health and Developmental Disabilities; **Faye Taylor**, Commissioner, Department of Education

The Children's Health Initiative

Pictured from left: Holly McDaniel, Joe McLaughlin, Ph.D., Mary Griffin, J.D., Patti van Eys, Ph.D.

"The Steering Panel has provided a forum to identify barriers to services for children with special health needs. But more importantly, it has allowed public and private health providers and state department representatives to discuss possible ways to tear down the barriers and start developing a system that is more responsive to children and their families. Advocates, mental health professionals, private pediatricians, as well as specialty physicians from tertiary children's hospitals have devoted a great deal of time to this Panel just to make the lives of children better in Tennessee".

Fredia Wadley, M.D., Commissioner of Health

Tom Mitoraj, M.D.
Pediatrician, Youth Care Pediatrics
Bristol, Tennessee

David Moroney, M.D.
Medical Director, TennCare Services
Blue Cross Blue Shield of Tennessee
Chattanooga, Tennesee

Michael Myszka, Ph.D.
Psychologist with the Office of Medical Director
Bureau of TennCare
Nashville, Tennessee

Linda O'Neal, J.D.
Executive Director
Tennessee Commission on Children and Youth
Nashville, Tennessee

Frederick Palmer, M.D.
Director, UT Boling Center for Developmental Disabilities
Memphis, Tennessee

Andres Pumariega, M.D.
Director, ETSU Center of Excellence
Johnson City, Tennessee

Judy Regan, M.D.
Medical Director, Department of Mental Health and Developmental Disabilities
Nashville, Tennessee

Linda Ross, J.D.
Deputy Attorney General, Office of the Attorney General and Reporter
Nashville, Tennessee

Clifford A. Seyler, M.D.
Pediatrician, Tullahoma Pediatrics
Tullahoma, Tennessee

Jacqueline Shaw, M.D.
Pediatrician, Family Health Services
Chattanooga, Tennessee

Laura Stewart, J.D., MTS
Executive Assistant to the Commissioner
Department of Children's Services
Nashville, Tennessee

William Terrell, M.D.
Pediatrician, Memphis and Shelby County Pediatric Group
Memphis, Tennessee

Larry Thompson, Ph.D.
Deputy Director, Office of Managed Care, Department of Mental Health and Developmental Disabilities
Nashville, Tennessee

Patti van Eys, Ph.D.
Mental Health Coordinator
Tennessee Children's Health Initiative
Nashville, Tennessee

Ellyn Wilbur, MPA
Vice President, TennCare Partners II, Advocare of Tennessee
Nashville, Tennessee

Diana Yelton, CMSW, MA
Program Healthcare Advocacy
Tennessee Department of Children's Services
Nashville, Tennessee

Paul Demuro
Consultant
Montclair, New Jersey

TennCare and Children Workgroup

Joseph McLaughlin, Chair
Tennessee Children's Health Initiative

Pam Brown
Tennessee Commission on Children and Youth

Mary Griffin
Tennessee Children's Health Initiative

Tony Halton
Tennessee Homeless Coalition

Dara Howe
Family Voices of Tennessee

Amy Jackson
Tennessee Healthcare Campaign

Kacie Fitzpatrick
Implementation Team, Department of Health

Holly McDaniel
Tennessee Children's Health Initiative

Louise Morris
Tennessee Healthcare Campaign

Connie Nelson
Tennessee Voices for Children

Patti van Eys
Tennessee Children's Health Initiative

Public Health EPSDT Activities

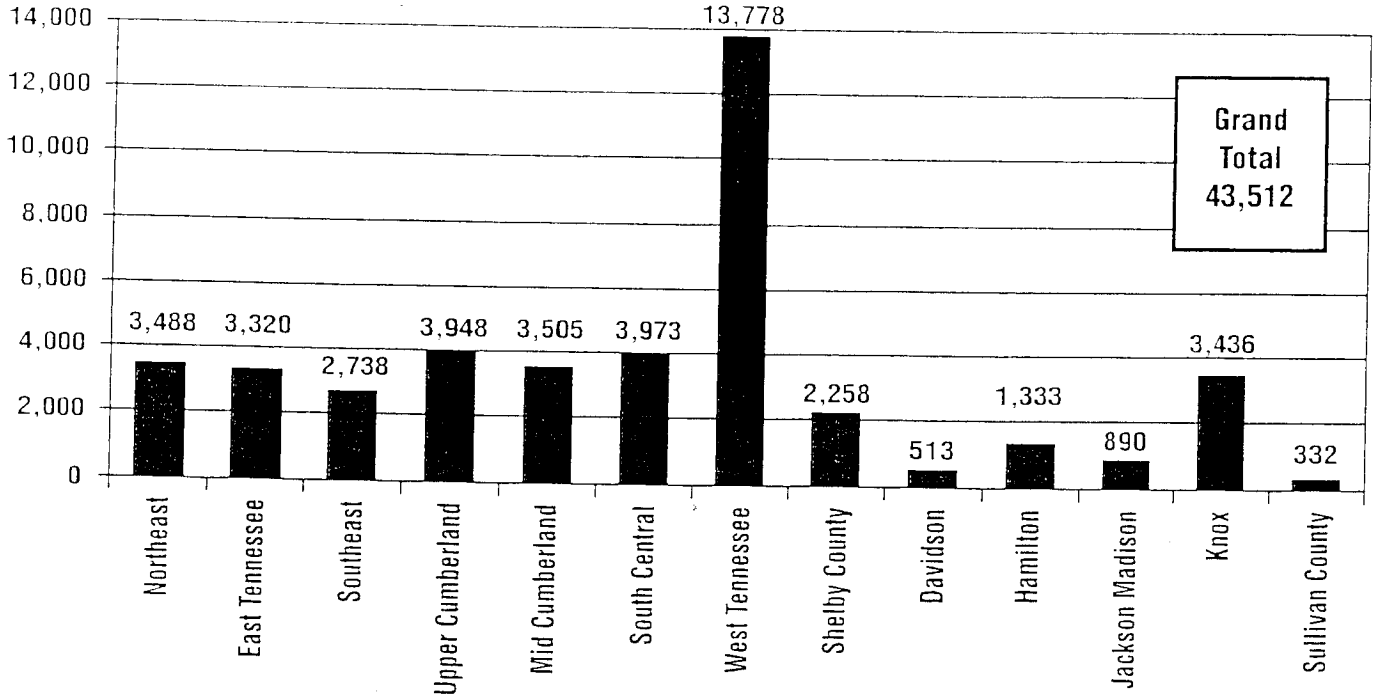
In an effort to boost EPSDT screening rates for TennCare eligible children, the Bureau of TennCare entered into a contract in 2001-2002 with the Department of Health to perform EPSDT screens. Local health departments, serving each of the 95 Tennessee counties, offer accessible venues for well-child screens, particularly in rural areas where there is a limited number of child health specialists. Regionally, Health Departments have initiated innovative outreach efforts that are paying off. This vital resource, with EPSDT services under the leadership of Dr. Wendy Long and Annette Goodrum, RN, has already proven its worth by performing 43,512 screens in the past fiscal year (7/0/01-6/30/02), with an average of 5,000 a month in the last six months of this time period. The Health Department staff are obtaining solid training on the physical assessment components of EPSDT through courses at Belmont and Union Universities and traveling faculty from East Tennessee State University. Additionally, nurses received in-depth training on the importance of completing and documenting all seven required components of the EPSDT screen.

Below are the statistics by county of the health department screenings in this first year of operation.

- Complete health history including developmental and behavioral screening;
- A complete physical exam;
- Lab work;
- Immunizations;
- Anticipatory guidance and health education;
- Hearing screening;
- Vision screening

Health Department EPSDT Screenings

July 1, 2001 - June 30, 2002



Staff of many local health departments are meeting with private physicians to facilitate the coordination of EPSDT exams.

Upper Cumberland is placing pamphlets in children's clothing stores, consignment stores, Goodwill, and other retail locations.

Northeast Region has established an effective tracking system that contacts families when the next EPSDT exam is due.

Mid-Cumberland Region is linking WIC and EPSDT. WIC vouchers are given for one month and an EPSDT screen is scheduled. The family must come for the screen in order to gain additional WIC vouchers.

Regions have developed brochures and conducted newspaper interviews to promote EPSDT.

as a condition of participation, working through the Women, Infants and Children (WIC) nutritional program to improve the immunization status of program participants, and implementing the Vaccines for Children program in Tennessee that provides $8.5 million worth of vaccines to private physicians for eligible children each year.

"Some of the problems we have identified through EPSDT exams include hearing problems, dental decay, heart murmurs, speech delays and behavioral disorders... Referring these children early for treatment has given them a better chance for healthy lives."

Shelnessa Cole
Nursing Supervisor
Wilson County Health Department

Right: Fredia Wadley, M.D., Commissioner of Health *Below Left:* Wendy Long, M.D., MPH with Stephanie Hewgley,a nurse practitioner at the Williamson County Health Department.

"Local health departments in every county of the state are now actively involved in the delivery of EPSDT screens and health department staff performed over 43,000 EPSDT screens in the first year of operation. Far more important than statistics, though, are the stories of individual children whose lives have been changed for the better because of early identification and treatment of health care problems. I have the great fortune to hear such stories on a regular basis from dedicated public health nurses and physicians throughout the state. I am very grateful for the role the Children's Health Initiative played in making these services a reality."

Wendy Long, MD, MPH
Health Services Administration

Tennessee Chapter of the American Academy of Pediatrics

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) entered into a contract with the TennCare Bureau on July 1, 2001, to work with the state to improve the quality and quantity of EPSDT screenings and other child health services. TNAAP has been involved in the EPSDT Workgroup, a collaboration of the MCOs and the TennCare Bureau under the leadership of Dr. Conrad Shackleford, to improve outreach and coordination in the provision of EPSDT services, as well as continuing to meet regularly with the Children's Health Initiative and the Department of Health to plan child health service improvements.

TNAAP members were involved in the development and review of the *"Tennessee Caring for Kids"* EPSDT Provider Video and CyberCE on-line educational sessions for Primary Care Providers. TNAAP has also been actively involved in the development of the EPSDT public awareness campaign "Tennessee Caring for Kids" materials (poster, brochures, TV and radio spots).

TNAAP has provided leadership in clarifying appropriate use of CPT (billing) codes both to provide accurate data about services and to support appropriate reimbursement of providers. TNAAP conducted focus groups with physicians to assess barriers to care and physician participation in TennCare.

TNAAP has also led the way in making revisions in the age-specific, well child forms recommended for use in EPSDT screening visits. As was the case with the previously disseminated set of well child forms developed by TNAAP, the revised forms serve as prompts for health care professionals to provide the full complement of EPSDT screening services appropriate to each age group and provide a convenient means of documenting these services. The revised forms are available on the TNAAP web site (www.aap.org) and on the TennCare web site (http://www.state.tn.us/tenncare). TNAAP, the MCOs, and the TennCare Quality Oversight division are also distributing the forms.

TNAAP took a leadership role in a Medical Home Planning Project designed to educate providers and communities about implementation of the Medical Home concept. The Medical Home model ensures that each child patient has a medical provider with primary responsibility for his or her individual care and has the full set of medical records so that health care can be optimally planned and coordinated. For example, a child in the foster care system who may be moved from one placement to another would have continuous health care if he or she had a consistent medical home.

Dr. Lloydetta Stovall, member of the Tennessee Chapter of the American Academy of Pediatrics, performs EPSDT screens at a Health Fair (sponsored by state Senator Roscoe Dixon) in Memphis, July 2002.

Photo courtesy of The Memphis/Shelby County Medical Society taken by Janice Cooper, Executive Assistant

Numerous EPSDT-related articles have been published in the TNAAP newsletter. TNAAP also established dialogue with the Tennessee Academy of Family Physicians (TAFP) regarding TNAAP's EPSDT activities and made the newsletter articles available to them for publication in the TAFP newsletter. TNAAP has continued to serve as a resource to the state for information on the most current national standards related to pediatric care and national coding practices and trends, such as the recent trend to begin reimbursing separately for hearing and vision screens. Also, a TNAAP representative and a Health Department representative now act as liaisons to address physician concerns that arise related to the Health Departments providing EPSDT screens.

Additional TNAAP efforts for fiscal year 2002-2003 will include: 1) education of primary care providers at practice sites about both EPSDT services and coding; and 2) participation in the feedback process with providers after the audits conducted by the TennCare Quality Oversight division.

F. Joseph McLaughlin, Ph.D., director of the Children's Health Initiative, receives the 2002 Friend of Children Award from the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). Joseph F. Lentz, M.D., TNAAP's Immediate Past President and recipient of the 2002 Pediatrician of the Year Award, accompanies him.

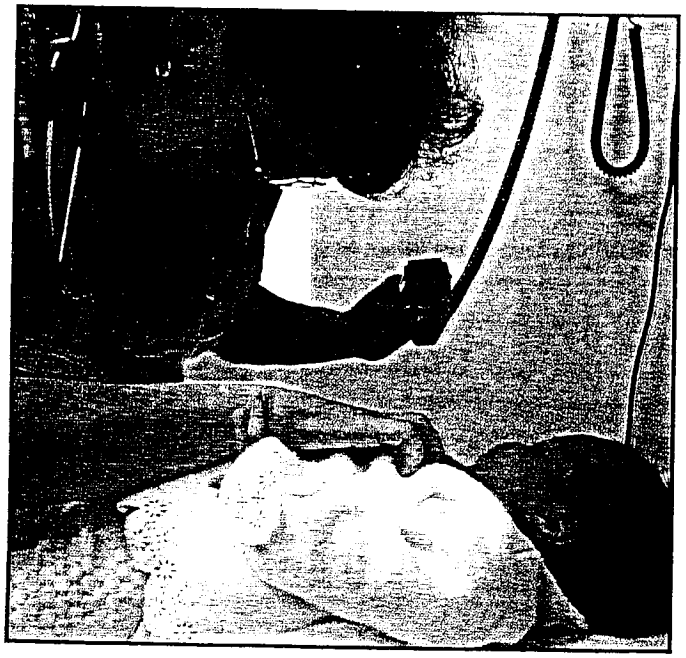
"The Children's Health Initiative is highly valued by Tennessee pediatricians. By bringing together providers and many of the pertinent state agencies, it provides a single coordinated point of contact for children's issues impacted by TennCare. Thanks to the Children's Health Initiative, we feel that our voice is better heard."

Dr. John C. Ring, President
Tennessee Chapter of the American Academy of Pediatrics

Approximately 4,500 videos and materials have been distributed to providers and health care organizations, including: primary care providers (family doctors, pediatricians, nurses); Health Departments; Even Start programs; Head Start Programs; Managed Care Organizations; health-related professional schools; and health care advocacy groups.

This high quality, informative video has received positive reviews from the field. In addition to this video educational outreach effort, the Tennessee Children's Health Initiative has led numerous trainings regarding children's physical, mental, and dental health care needs. Such trainings have included:

- Annual juvenile court judge's conferences;
- Advocare provider trainings;
- Tennessee Association of Mental Health Organization Child and Youth subcommittee meetings;
- Tennessee Voices for Children Board meetings;
- Tennessee Voices State of the Child Conference 2002 and Annual Convention;
- Community Services Agency Family Crisis Intervention Team;
- Children with Special Health Needs Conference;
- Policymakers' Discussion on Children's Health ;
- TennCare Partner's Roundtable Children and Youth committee;
- Tennessee Commission on Children and Youth Children's Advocacy Days 2002;
- Tennessee Chapter of the American Academy of Pediatrics meetings;
- Tennessee Conference on Social Welfare;
- Tennessee Association of Mental Health Organization Annual Conference



Shelnessa Cole, R.N., PHN4, performs an EPSDT exam at the Wilson County Health Department

"The Children's Health Initiative has been a great partner in the first two annual Policymakers' Discussions on Children's Health. I think ideas that have come up at the Policymakers' Discussion have been useful in trying to bring up EPSDT screening rates and it is great that they've been there to help foster a positive environment of discussion and to act on solutions as well as barriers to care for children."

Amy Jackson, Program Director, Early Child Health Outreach (ECHO)

In addition, efforts have been made to develop on-line educational resources for providers, both through the contract with the on-line educational services company, CyberCE, and by additions to the TennCare web site (http://www.state.tn.us/tenncare). The TennCare web site includes information on screening guidelines, recommended age-specific well child forms, a link to the Pediatric Symptom Checklist (a validated behavioral health screening instrument), information on immunization, and Health Department information.

"We can always count on the staff at the Children's Health Initiative to present professional, objective and comprehensive reports on children's health policy and strategy. It is clear that the CHI's agenda is to improve children's health. We all appreciate their openness and clear dedication to their mission."

Charlotte Bryson, Executive Director, Tennessee Voices for Children

Children's Oral Disease Prevention Services

Great improvements in children's dental care were achieved in 2001-2002. The Children's Oral Health Planning Group, chaired by the Children's Health Initiative, comprised of dentists, dental specialists, and interagency state staff representatives, focused on three major thrusts to improve dental services for children: 1) a "carve-out" of dental services under TennCare; 2) the School-Based Dental Prevention Project by the Department of Health and 3) involvement and support of organized dentistry to promote and encourage participation of dentists as providers in the dental carve-out.

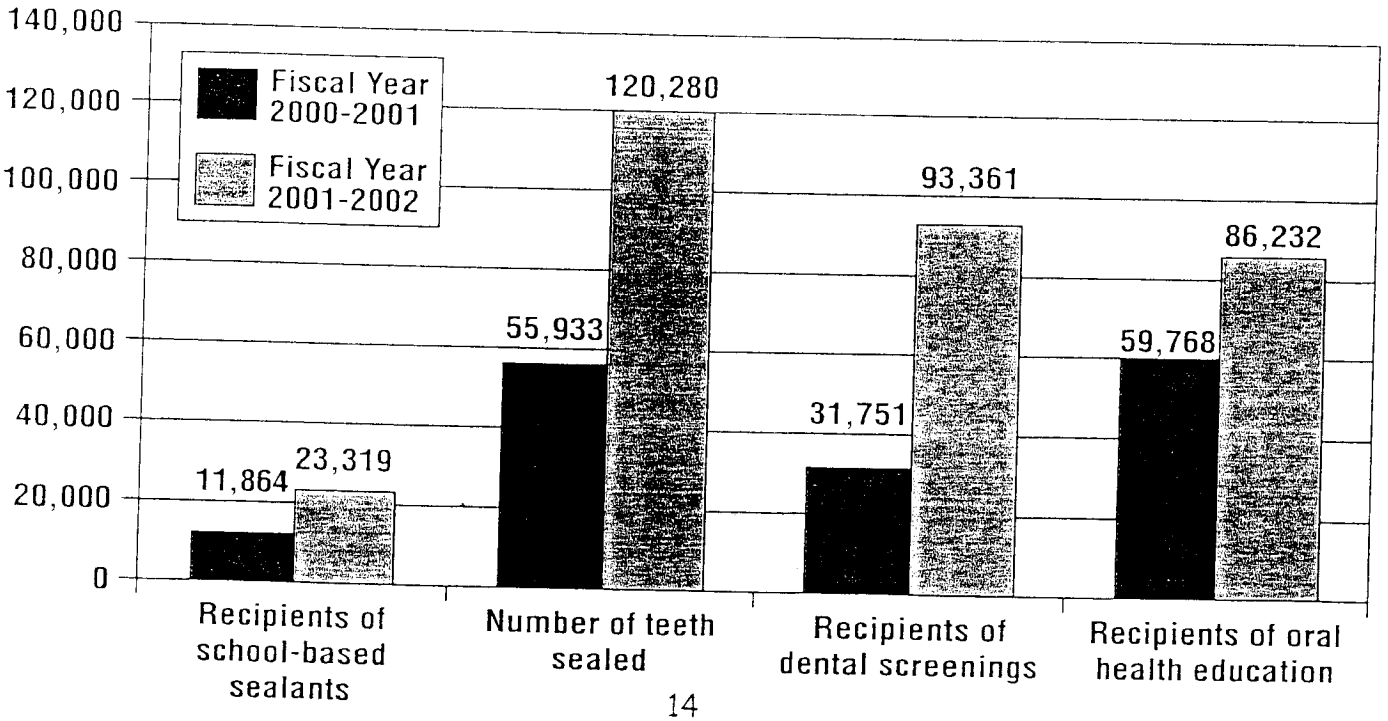
The dental carve-out, which became operational October 1, 2002, has a single dental benefits manager, Doral Dental Services, and has attracted a larger number of dentists into the provider network. Professional associations of dentists, such as the Tennessee Dental Association and the Pan Tennessee Dental Association, have actively encouraged their membership to become TennCare providers. Children's access to both preventive care and treatment will be much improved.

The School-Based Dental Prevention Project, a collaboration between TennCare and the Department of Health, has enabled thousands of children to receive dental preventive services within the school setting in fiscal year 2001-2002. Prior to the enhancements, the school-based program served about half of the number of children as it has in the past year. Increased staff, newly developed staffing patterns and additional equipment have allowed the program to greatly expand preventive dental services to children. Following is a chart comparing the dental activities from last year to this year within the school-based program.

Mary McClean, RDH, "cleans" teeth and gums for health promotion and dental health education.

In order to more accurately measure, report, and evaluate the success of the school-based dental prevention project, the Bureau of Health Services developed a computer system using

Children's Oral Disease Prevention Services Data Comparison



Progress in Accessing EPSDT Services for Children in State Custody or at Risk of Custody

Centers of Excellence for Children in State Custody and at Risk of State Custody

The Children's Health Initiative, in coordination with TennCare and the for Children with Special Health Needs Steering Panel, has collaborated with five tertiary pediatric centers across the state to institute the Centers of Excellence (COEs). The five centers are located in the West, Middle, East, Northeast, and Southeast Regions (see map). Three COEs are currently in operation. Vanderbilt since January 2002, UT-Memphis Boling Center since February 2002; and East Tennessee State University since August 2002. Chattanooga (Southeast) and Knoxville (East) are expected to open by 2003. These Centers of Excellence serve children, identified primarily by the Department of Children's Services, who:

- Are TennCare enrollees;
- Are in state custody or at risk of custody;
- Have complex behavioral and/or medical needs;
- Have had difficulty finding access to adequate health and mental health services

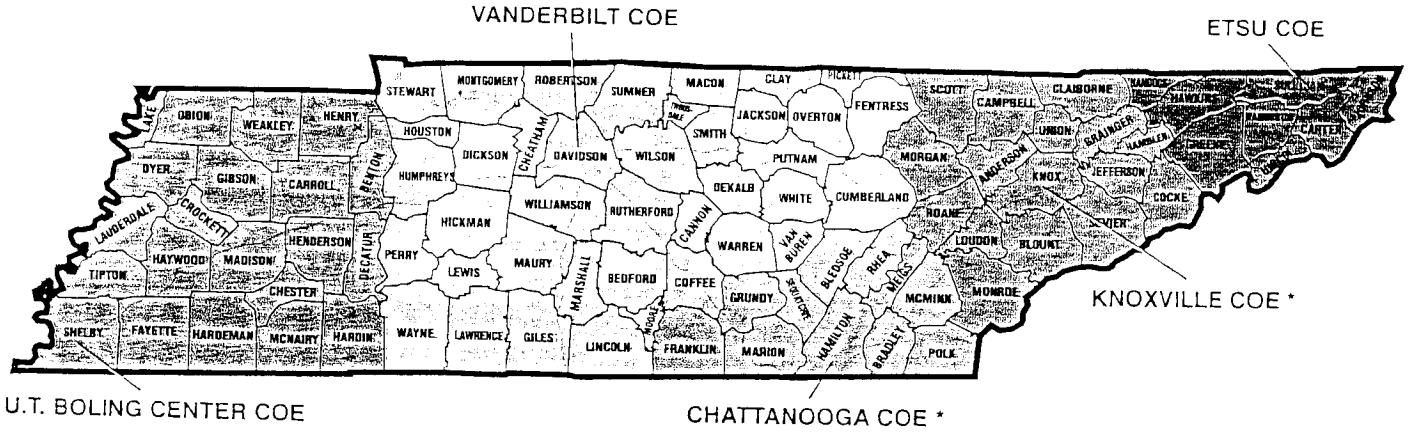
In addition to referrals from the Department of Children's Services, other referral sources include primary care providers, mental health professionals, juvenile justice staff, advocates, and caregivers.

"Andrew", age four, had disrupted two placements in the 8 months he'd been in DCS custody due to severe behavior problems, including aggression, self-biting, defiance, and toileting problems. Residential placement was being considered when he was referred to the COE for an evaluation. As a result of the evaluation, it was determined that, due in part to mental retardation, Andrew's current level of functioning was similar to a 2-year-old child. In a meeting with Andrew's case managers and his new foster mother, all were encouraged to understand and respond to Andrew's behaviors in the context of his developmental level. Andrew was referred for needed behavioral health and special education services. Andrew has remained in the current foster home.

UT-Boling Center of Excellence for Children in State Custody

The Centers provide expert services, primarily in the areas of comprehensive assessment and consultation, for children with complex needs who require sensitive coordination of care. The Centers provide the continuity and coordination of care through evaluation and subsequent consultation to the network of providers. In addition to serving individual children, the Centers also promote the development of the TennCare Pediatric Best Practice Network by both encouraging and supporting health profes-

Centers of Excellence



* Not operational, projected by 2003

Overview of Services

- Case consultation and triage;
- Training and education to DCS staff and TennCare providers;
- Case coordination;
- Case review;
- Network development and monitoring;
- Psychiatric evaluations;
- Psychiatric medication management;
- Psychological evaluations;
- EPSDT screenings

providers in the field, the initial services data from the Centers, and most importantly from the children's own stories about their enhanced level of health and mental health and its effects on their well-being.

"Juan" is 16 year old deaf, mute, undocumented immigrant referred to the COE due to being ineligible for TennCare and at high risk for being removed into state's custody. Juan's father had recently died before acquiring a green card and Juan had come under state concern due to charges of domestic violence, as he had assaulted and injured his mother. Juan had recently been discharged from a psychiatric hospital with diagnoses of mood and conduct disorders and was being treated with medication, but had no follow-up psychiatric care. The Center's ability to fill this gap in service and provide psychiatric follow-up with continued medication adjustments has helped keep Juan stay out of custody. Juan has had no additional violent episodes and is excelling in public school.

Vanderbilt University Center of Excellence for Children in State Custody

"Mary," a 13 year old girl who was severely abused and developed post-traumatic stress disorder and dissociative identity disorder, was due to be discharged from a residential facility back to her foster home without treatment to address the severe trauma that elicited frequent and dangerous violent outbursts when in the more stressful "real world". Psychiatrists at the COE not only had previously accurately diagnosed her disorder, but later contributed to the negotiation of a community-based intensive treatment plan in an administrative court hearing of a TennCare appeal, working with her advocacy attorney and the DCS Health Unit. The plan will enable Mary to receive the appropriate treatment she needs in her community, but in a setting which will provide safety for her and her foster family.

ETSU Center of Excellence for Children in State Custody

Below is initial service data from April-June 2002, the first quarter when two of the COEs (Middle and West) were fully operational. As the COEs continue to develop, service numbers will increase significantly.

- 128 children were linked to services through triage calls;
- 79 children received psychiatric services;
- 109 children received psychological services;
- 19 children received pediatric services;
- 20 sets of professionals were formally trained in aspects of mental health issues

"This organized effort brought to the forefront the medical and behavioral health care challenges that children in state custody or at risk of custody frequently experience and assisted in the coordination of efforts among agencies to meet the needs of our children."

Commissioner
Page B. Walley, Ph.D.
Department of Children's Services

Implementation team members confer on a case. Pictured from left: Kacie Fitzpatrick, Larry Faust (director), Mary Jo Heimbigner, and Carla McCord

Twelve-year-old "Sarah" has a history of sexual abuse and longstanding problems with angry outbursts, including aggression towards others, destruction of property and multiple psychiatric hospitalizations. A Center of Excellence evaluation determined her diagnoses to include Post Traumatic Stress Disorder, Oppositional Defiant Disorder and a history of Major Depressive Disorder. The COE recommended residential behavioral health treatment. Sarah's outpatient therapist advised against placement in a standard residential treatment center due to the risk of victimization. An Implementation Team member negotiated authorization by the BHO for Individualized Residential Treatment (non-custodial therapeutic support home), thus avoiding commitment to DCS custody to access the most appropriate level of care to meet Sarah's needs.

Mary Jo Heimbigner, MSW, Implementation Team, Department of Health

"John" is a 17-year-old whose provider recommended residential treatment for behavioral problems. Although denied by the BHO on the basis of the clinical information provided, the court ordered that residential placement be provided or John would be placed in state custody. The Implementation Team (IT) was contacted. After gathering further information, the IT was concerned that John's behavior could be consistent with drug abuse. The IT was able to arrange a drug and alcohol evaluation that confirmed a drug abuse/addiction problem. Based on this additional information, the BHO approved a residential program for drug issues, thus avoiding custody.

Larry Faust, MD, Implementation Team, Department of Health

- A Commissioners' EPSDT Task Force workgroup to study the quality of discharge reports and recommendations from the Regional Mental Health Institutes (RMHI);
- A collaboration with the Regional Mental Health Institutes to implement the suggestions from the above EPSDT Task Force workgroup in addressing the quality of assessment information that impacts recommended discharge services from RMHI providers;
- Creation of a subcommittee reporting to the Commissioners' EPSDT Task Force with representatives from Department of Children's Services, Implementation Team, Department of Education, and Division of Mental Retardation Services to look into the issue of education of children in treatment placements outside their county of residence

There has been successful change in the percentage of children that entered custody in the two years of the Implementation Team operation as follows:

- 20% of referred "at-risk" children entered custody between June 2000 and June 2001,
- 12% of referred "at-risk" children entered custody between June 2001 and June 2002

The children who entered custody did so for child welfare and juvenile justice reasons rather than for lack of behavioral health services, reflecting the effectiveness of the Implementation Team in facilitating appropriate services for children at risk.

Carla McCord, executive secretary of the Implementation Team, receives a case referral.

children from rural Appalachian counties enter state custody at a higher rate than children from urban areas. The proposed project will reach 360 families with the MST intervention; outcomes with these families will be compared with outcomes of 360 families who will receive services as usual.

This proposal is in the last stages of review at NIMH and is likely to be funded within the 2002 calendar year. This venture represents the cutting edge of mental health services research and the results of the study should have national significance for improving services to rural children at risk of out-of-home placements.

> *"The Children's Health Initiative has been instrumental in coordinating the submission of a research grant proposal to the National Institute of Mental Health to study the efficacy of an intervention model (MultiSystemic Therapy) on reducing the number of children adjudicated to state custody. We appreciate the CHI's commitment to efforts aimed at reducing the number of children going into state custody."*
>
> Charlotte Bryson, Executive Director, Tennessee Voices for Children

Children with Mental Retardation (MR) and other Developmental Disabilities (DD)

Many children with MR/DD issues also have significant behavioral health needs. Their families often require support, such as in-home assistance, respite services, family counseling, and special behavioral skills training, in order to best parent their children.

To begin to address these needs, efforts at the state level have included:

- a comprehensive study, chaired by the Children's Health Initiative, and involving several State agencies to examine the needs and gaps in services for these children;
- a proposal for a full continuum of services for these children and a plan for developing expertise in the network;
- a commitment from TennCare to supply extra dollars for this population;
- a commitment from the BHO to work up a plan to serve these children

Presently, the BHO is working to devise a service plan to meet the needs of children with MR/DD and behavioral health problems. Meanwhile, some service providers in the state are stepping forward with resources to plug into this gap in the system of services. While the state is getting closer to having a system for the kinds of specialized services in place for these dually diagnosed children, other recent efforts have been started in the the meantime to address the short term needs. These include a push by the Division of Mental Retardation Services and the Disabilities Coordinator of TennCare to obtain a Medicaid exception to the federal moratorium on the MR waiver when children are in crisis (e.g., about to enter custody in order to get services for their difficult behaviors).

This exception has allowed the Implementation Team to write Letters of Authorization for these children to be placed in treatment options that are uniquely created for their special needs while they are in the process of getting longer term MR waiver services. For example, in working with Youth Villages, a provider for children's mental health needs across the state, the Implementation Team has worked out individualized service plans for dually diagnosed children that consist of such services as Professional Support Home (a family-based therapeutic setting with specially trained caregivers), behavioral specialists who work with the child on protocols for difficult behaviors, and therapists who work with the family of origin in order to help them prepare to receive the child back in the home. These children are now getting their unique needs met and making progress.

Finally, the Centers of Excellence for Children in State Custody have conducted in-service training events for providers on the topic of children with the dual diagnoses of mental retardation and behavioral health problems. Also, the Centers have been conducting excellent evaluation and follow-up consultation for children in state custody who are dually diagnosed and whose needs have been a challenge to meet appropriately.

A further step in the right direction for children with special needs is the Interdepartmental Autism Study Group. This group, chaired by the Children's Health Initiative, has been asked by the legislature to study the services in the state of Tennessee that directly aid children with autism, and to propose a plan for a comprehensive statewide integrated service model for children with autism. This group, with three focus groups (parents, providers, state interdepartmental leaders) began meeting in September 2002 and will submit a plan by December 2002 to a special legislative committee that will carry it forward to the General Assembly in 2003.

Tennessee Caring for Kids: Caring for Our Future

F. Joseph McLaughlin, Ph.D. Director, Children's Health Initiative

Working together we can continue to improve the lives of children. Nothing is more critical to the well-being of our communities and our state than the healthy development of all our children.

Two years of collaboration among parents, advocates, physicians, dentists, psychologists, nurses, social workers, community leaders, TennCare staff, and staff of child-serving departments of state government have resulted in many significant improvements in health care for children in Tennessee. It has been exciting and gratifying to work with such a large group of caring and competent people focused on the needs of children. Working together much has been achieved. And much remains to be done.

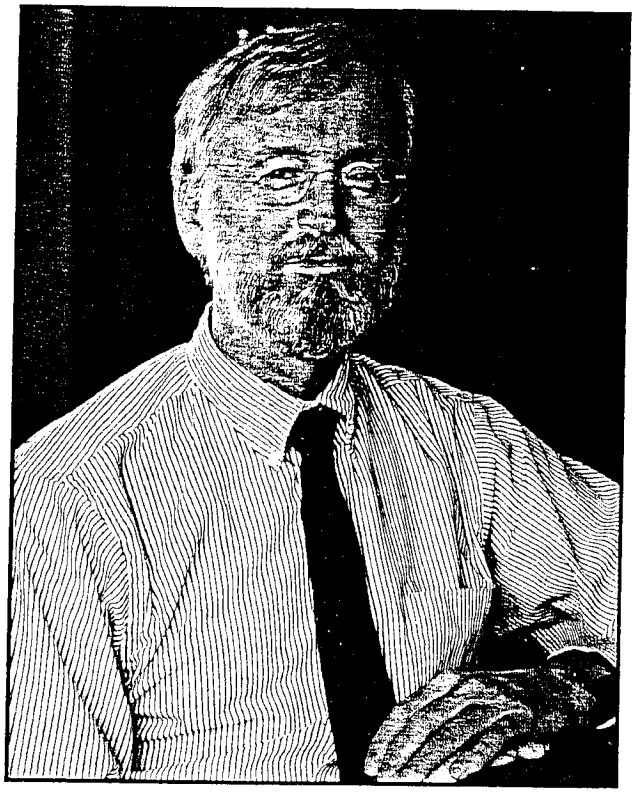
With the Health Department as a statewide provider of EPSDT, screenings have become much more available and accessible. Screening has also been improved through provider education and through the state's partnership with the Tennessee Chapter of the American Academy of Pediatrics. Screenings are the foundation of preventive health services and the gateway to treatment. The health and happiness of children depends on finding needs earlier and making connections between health care and behavioral health services that many children need desperately. Our next steps on screening should be:

- Development of more Medical Homes with accessible child health services from birth into adulthood;
- Use of developmental/behavioral screening tools to identify children who have developmental, emotional, and behavioral health needs;
- Integration of health and behavioral health services to meet the needs of the "whole child"

"Early results from the TennCare Select model are promising. The next step for Tennessee needs to be 'integrated whole child health care:' it is time to bring mental health and physical health together in a seamless fashion."

John Tighe
Deputy to the Governor for Health Policy

Michelle Vaughan, DDS, conducts an oral evaluation of a child in the school-based dental prevention project.



F. Joseph McLaughlin, Director of the Children's Health Initiative

thanks for the care you give

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Holly McDaniel

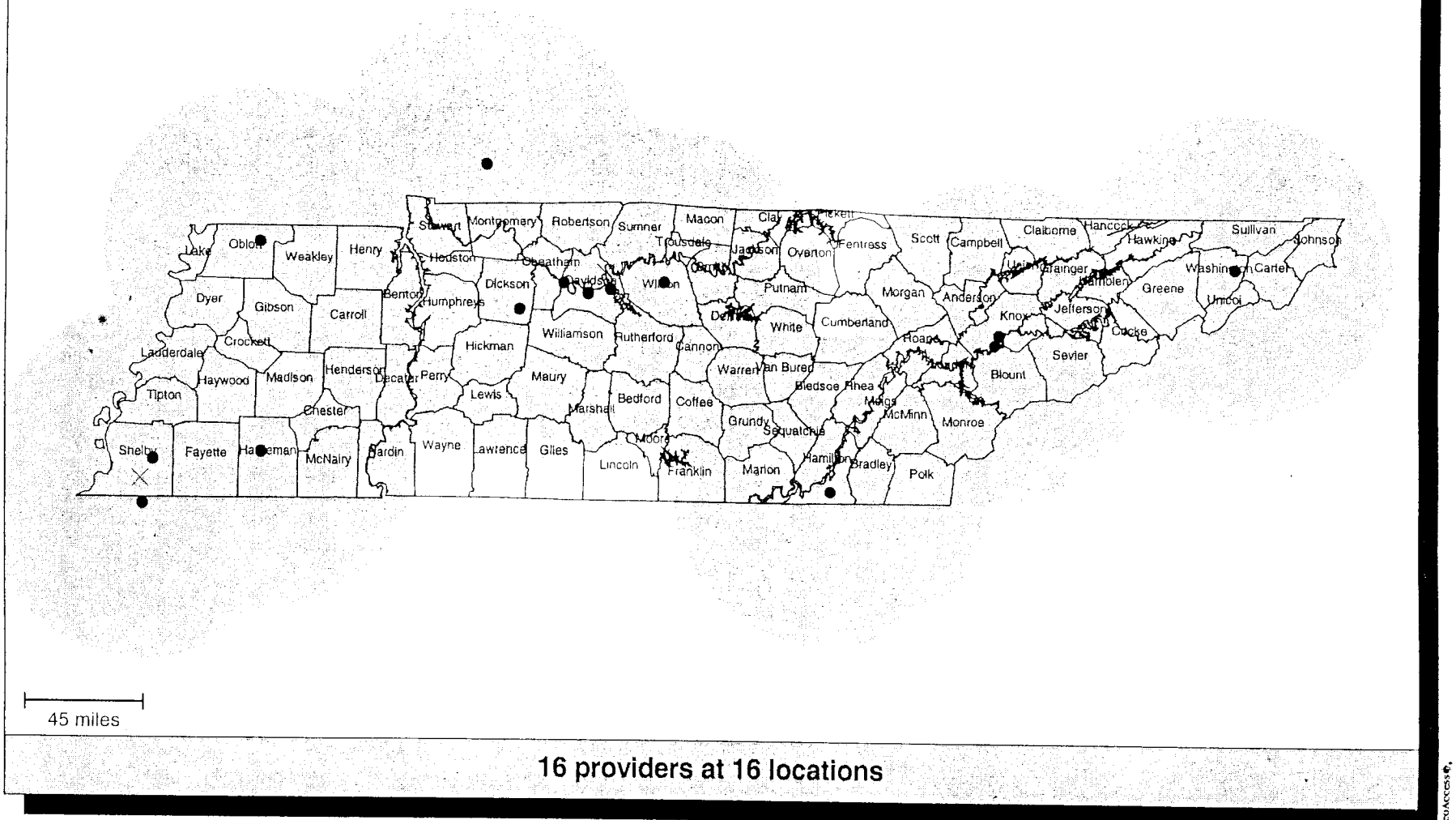
615-532-0499

CHILDREN & YOUTH PROVIDER NETWORK
OCTOBER - DECEMBER 2002

State of Tennessee
Bureau of TennCare and
Department of Mental Health and Developmental Disabilities
Office of Managed Care
Cordell Hull Building - 5th Floor
Nashville, TN 37243

Provider locations

Premier Inpatient Child - Facilities



16 providers at 16 locations

- ● Single provider locations (14)
- ⨯ Multiple provider locations (2)
- ☐ 60 mile radius

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PRENTISS - MS			
MARIETTA	38856	2	73.1
PENDER - NC			
BURGAW	28425	1	76.6
CARROLL - TN			
YUMA	38390	13	64.2
CUMBERLAND - TN			
CROSSVILLE	38571	1,123	64.6
PLEASANT HILL	38578	95	65.2
FENTRESS - TN			
CLARKRANGE	38553	322	66.4
GRIMSLEY	38565	195	68.9
JAMESTOWN	38556	1,743	71.2
WILDER	38589	29	65.4
FRANKLIN - TN			
HUNTLAND	37345	218	64.4
GILES - TN			
ARDMORE	38449	195	78.0
ELKTON	38455	60	76.7
GOODSPRING	38460	162	68.1
MINOR HILL	38473	90	72.0
PROSPECT	38477	211	74.8
PULASKI	38478	1,671	64.6
LAWRENCE - TN			
FIVE POINTS	38457	77	70.7
LORETTO	38469	315	70.3
SAINT JOSEPH	38481	92	75.8
WESTPOINT	38486	97	67.2
LINCOLN - TN			
DELLROSE	38453	34	71.1
ELORA	37328	129	69.5
FAYETTEVILLE	37334	1,795	73.0
FLINTVILLE	37335	270	73.2
FRANKEWING	38459	32	65.9
KELSO	37348	132	75.0
MULBERRY	37359	40	71.6
TAFT	38488	193	77.9
MOORE - TN			
LYNCHBURG	37352	201	65.4

Provider group: Premier Inpatient Child - Facilities

ZIP Code detail information

Premier Child

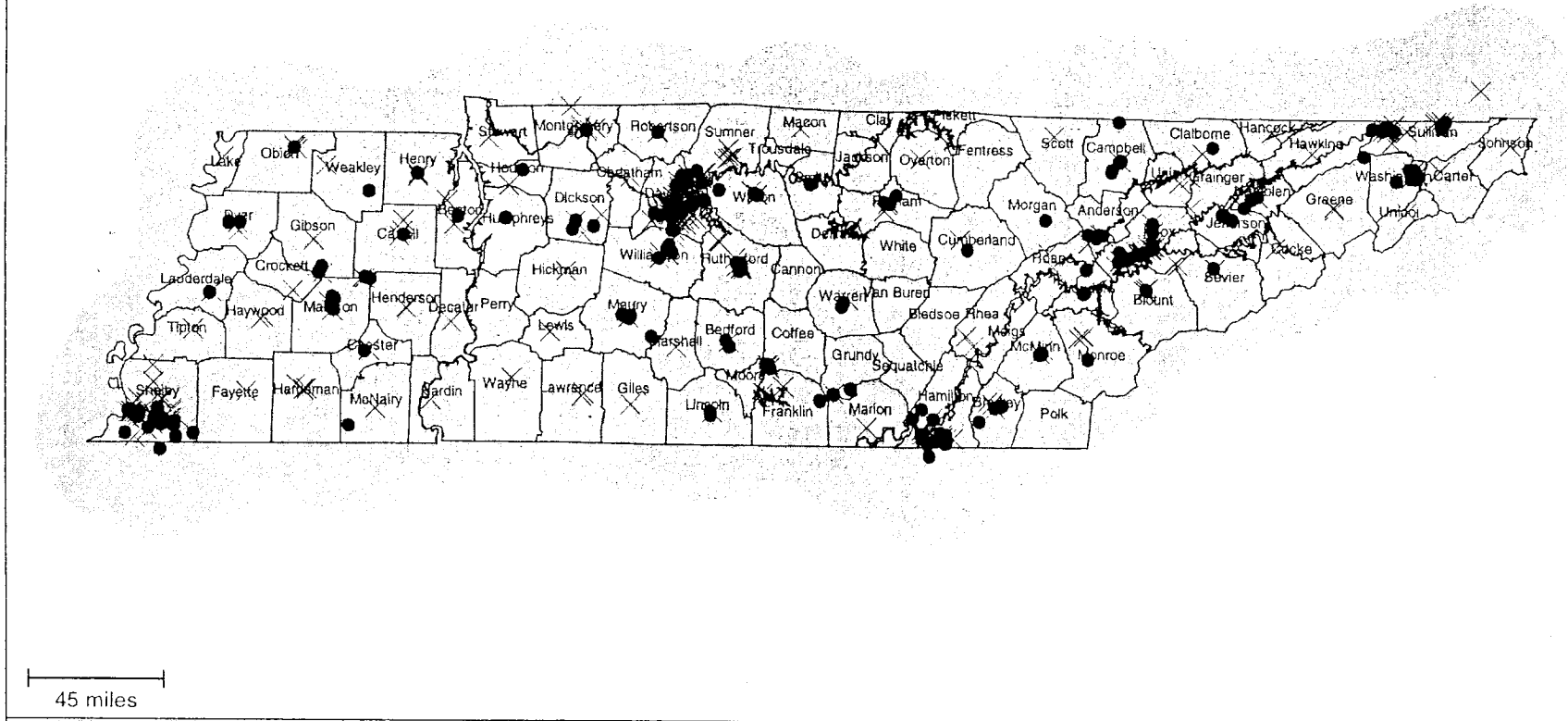
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
OVERTON - TN			
ALLONS	38541	163	64.7
ALPINE	38543	53	68.3
CRAWFORD	38554	112	64.3
MONROE	38573	221	68.6
PICKETT - TN			
BYRDSTOWN	38549	451	75.5
PALL MALL	38577	154	80.3
WAYNE - TN			
COLLINWOOD	38450	342	72.7
CYPRESS INN	38452	102	75.9
IRON CITY	38463	316	76.7
LUTTS	38471	70	68.7
WAYNESBORO	38485	805	64.0
TOTALS		**12,326**	**69.6**

GeoAccess®

Provider group: Premier Inpatient Child - Facilities

Provider locations

Premier Outpatient Child - Facilities



922 providers at 559 locations

- ● Single provider locations (223)
- × Multiple provider locations (336)
- ☐ 30 mile radius

GeoAccess®

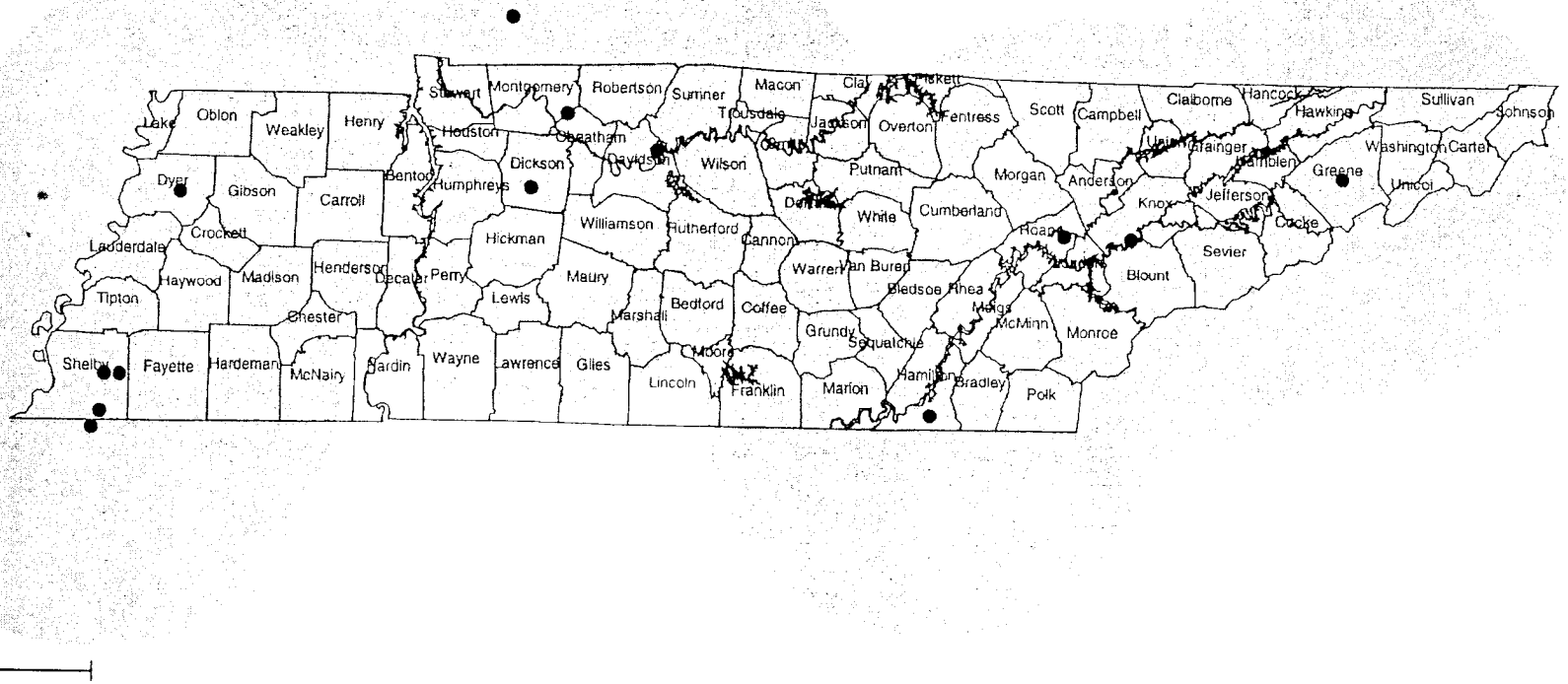
ZIP Code detail information

Premier Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
NO MEMBERS MEET THE SPECIFICATIONS			

Provider group: Premier Outpatient Child - Facilities

Provider locations

Premier RTF 24 Hour Child - Facilities



12 providers at 13 locations

- Provider locations (13)
- 70 mile radius

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PENDER - NC			
BURGAW	28425	1	76.9
CHESTER - TN			
ENVILLE	38332	39	75.1
CLAY - TN			
CELINA	38551	559	75.9
GILES - TN			
ARDMORE	38449	195	87.2
ELKTON	38455	60	83.9
MINOR HILL	38473	90	76.7
PROSPECT	38477	211	80.0
HARDIN - TN			
COUNCE	38326	71	83.0
CRUMP	38327	37	79.2
MORRIS CHAPEL	38361	43	79.1
OLIVEHILL	38475	26	76.7
SALTILLO	38370	17	77.9
SAVANNAH	38372	797	83.3
SHILOH	38376	19	77.8
HENDERSON - TN			
REAGAN	38368	86	75.1
SARDIS	38371	26	76.4
JOHNSON - TN			
LAUREL BLOOMERY	37680	79	75.9
LAWRENCE - TN			
SAINT JOSEPH	38481	92	74.5
LINCOLN - TN			
DELLROSE	38453	34	81.0
FAYETTEVILLE	37334	1,795	78.7
FRANKEWING	38459	32	75.5
KELSO	37348	132	75.1
MULBERRY	37359	40	75.3
TAFT	38488	193	84.6
MCNAIRY - TN			
ADAMSVILLE	38310	309	75.0
MICHIE	38357	187	77.1
MILLEDGEVILLE	38359	7	79.6
OVERTON - TN			
ALLONS	38541	163	78.1

GeoAccess®

Provider group: Premier RTF 24 Hour Child - Facilities

ZIP Code detail information

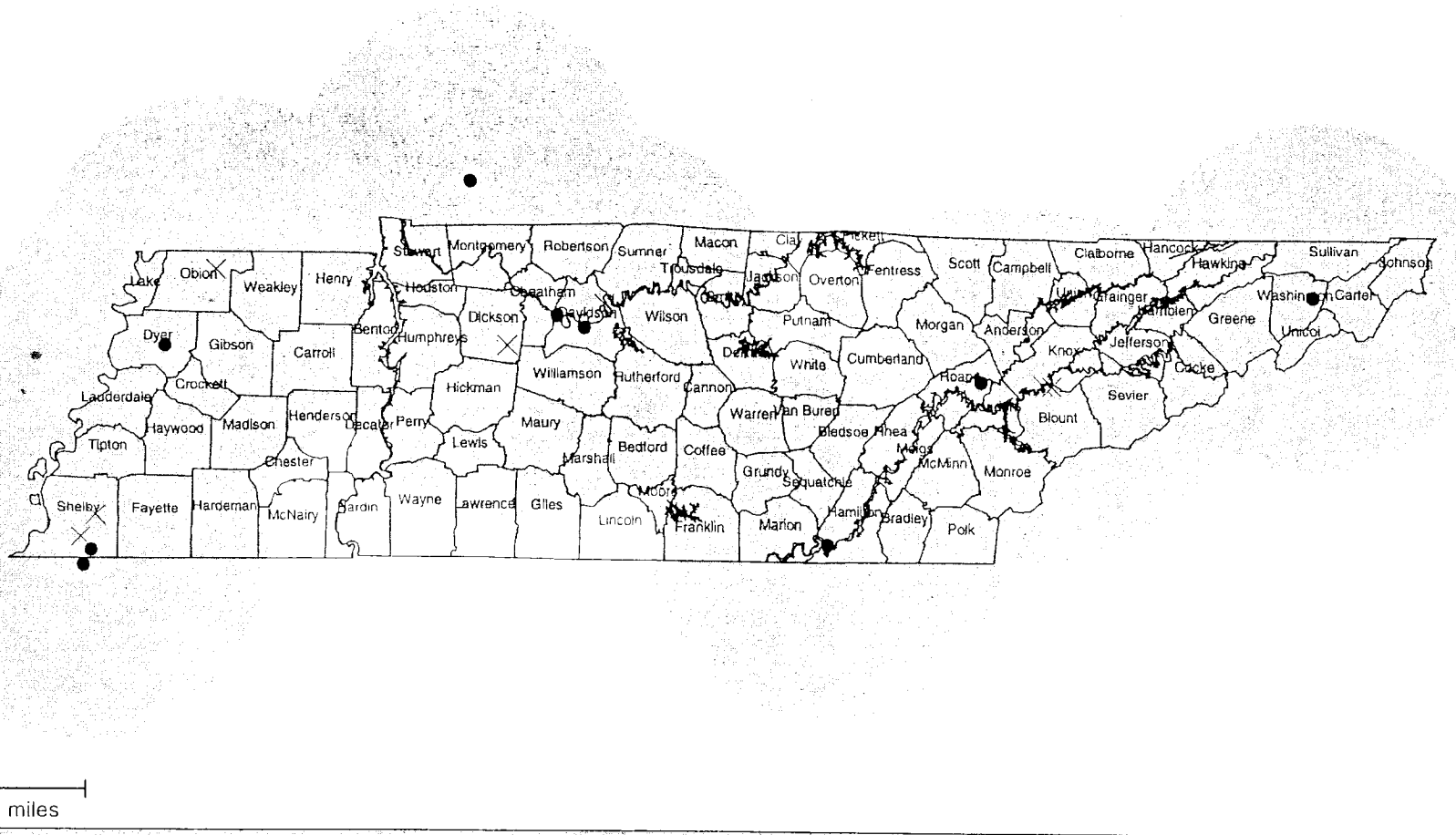
Premier Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
WAYNE - TN			
CYPRESS INN	38452	102	80.0
IRON CITY	38463	316	75.5
LUTTS	38471	70	82.8
TOTALS		**5,828**	**79.0**

GeoAccess

Provider group: Premier RTF 24 Hour Child - Facilities

Provider locations

Premier Substance Abuse Inpatient Child - Facilities



15 providers at 16 locations

- ● Single provider locations (9)
- × Multiple provider locations (7)
- ☐ 60 mile radius

GeoAccess®

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
MADISON - AL			
HUNTSVILLE	35806	1	67.0
PENDER - NC			
BURGAW	28425	1	79.0
BEDFORD - TN			
NORMANDY	37360	137	64.4
CHESTER - TN			
ENVILLE	38332	39	78.0
HENDERSON	38340	364	67.2
JACKS CREEK	38347	25	72.3
LURAY	38352	12	67.5
CLAY - TN			
CELINA	38551	559	75.9
MOSS	38575	154	69.2
DECATUR - TN			
BATH SPRINGS	38311	17	74.1
DECATURVILLE	38329	113	69.2
GILES - TN			
ARDMORE	38449	195	78.0
ELKTON	38455	60	76.7
GOODSPRING	38460	162	68.1
MINOR HILL	38473	90	72.0
PROSPECT	38477	211	74.8
PULASKI	38478	1,671	64.6
HARDIN - TN			
COUNCE	38326	71	85.8
CRUMP	38327	37	84.1
MORRIS CHAPEL	38361	43	83.7
OLIVEHILL	38475	26	79.9
SALTILLO	38370	17	81.8
SAVANNAH	38372	797	87.8
SHILOH	38376	19	82.6
HENDERSON - TN			
DARDEN	38328	38	67.8
HURON	38345	70	65.2
LEXINGTON	38351	846	65.7
REAGAN	38368	86	75.5
SARDIS	38371	26	80.4
SCOTTS HILL	38374	66	76.1

Provider group: Premier Substance Abuse Inpatient Child - Facilities

ZIP Code detail information

Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
HENDERSON - TN			
WILDERSVILLE	38388	59	64.0
LAWRENCE - TN			
FIVE POINTS	38457	77	70.7
LORETTO	38469	315	70.3
SAINT JOSEPH	38481	92	75.8
WESTPOINT	38486	97	67.2
LINCOLN - TN			
DELLROSE	38453	34	71.1
FAYETTEVILLE	37334	1,795	71.2
FRANKEWING	38459	32	65.9
KELSO	37348	132	64.2
MULBERRY	37359	40	64.8
TAFT	38488	193	76.8
MCNAIRY - TN			
ADAMSVILLE	38310	309	79.9
BETHEL SPRINGS	38315	201	65.7
CHEWALLA	38393	4	65.9
FINGER	38334	59	70.1
GUYS	38339	45	73.3
MICHIE	38357	187	79.7
MILLEDGEVILLE	38359	7	83.1
RAMER	38367	155	70.3
SELMER	38375	614	68.2
STANTONVILLE	38379	55	77.6
OVERTON - TN			
ALLONS	38541	163	78.1
ALLRED	38542	3	64.0
ALPINE	38543	53	66.0
HILHAM	38568	228	72.0
LIVINGSTON	38570	852	71.7
MONROE	38573	221	72.3
RICKMAN	38580	158	67.6
PICKETT - TN			
BYRDSTOWN	38549	451	73.5
PALL MALL	38577	154	68.3
PUTNAM - TN			
COOKEVILLE	38501	2,854	66.9
	38502	105	67.9

Provider group: Premier Substance Abuse Inpatient Child - Facilities

ZIP Code detail information

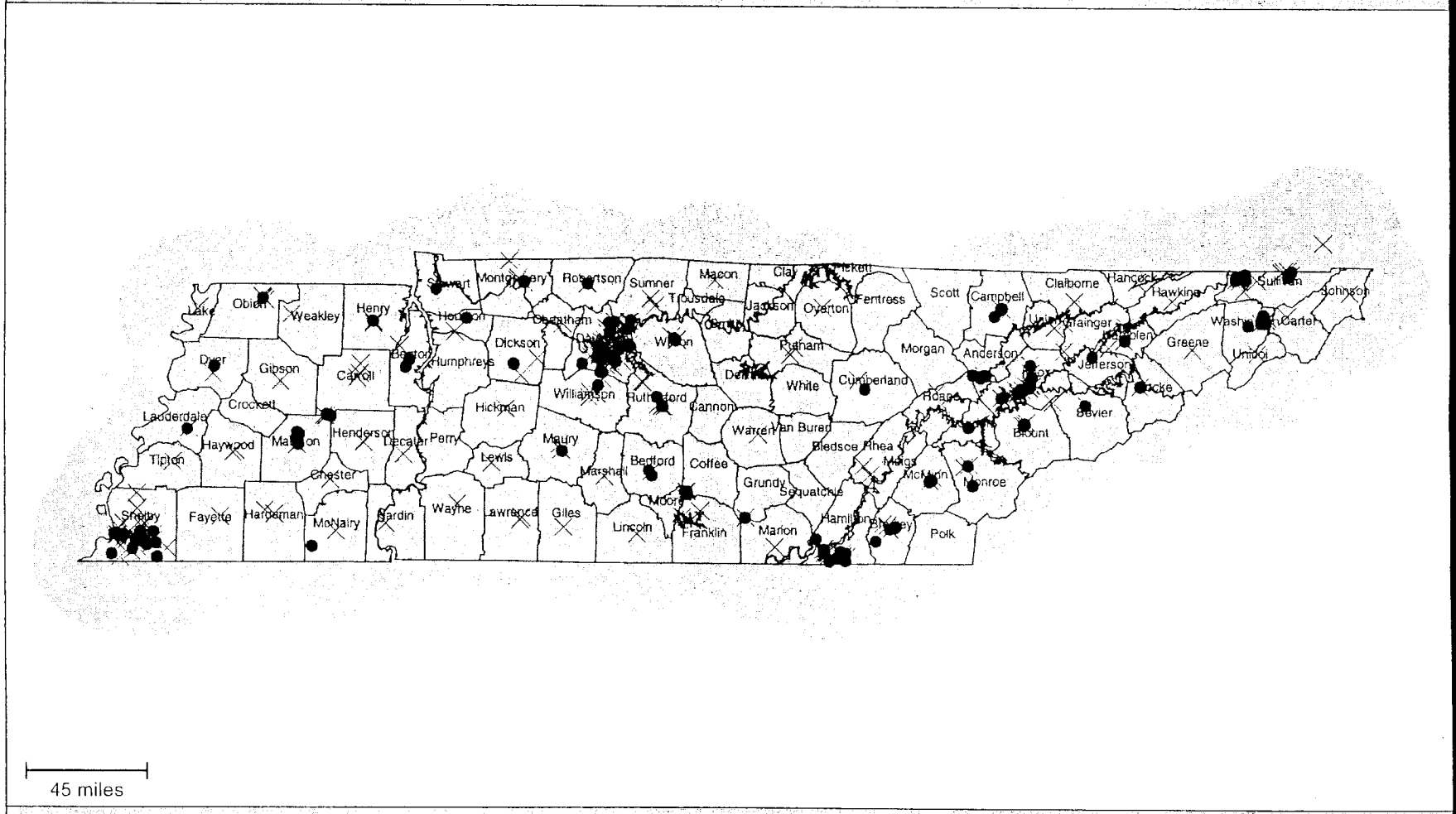
Premier Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
PUTNAM - TN			
COOKEVILLE	38503	52	68.4
	38505	4	65.8
	38506	1,829	68.5
WAYNE - TN			
CLIFTON	38425	182	71.0
COLLINWOOD	38450	342	74.2
CYPRESS INN	38452	102	82.2
IRON CITY	38463	316	77.2
LUTTS	38471	70	85.0
WAYNESBORO	38485	805	64.5
TOTALS		**19,399**	**70.5**

Provider group: Premier Substance Abuse Inpatient Child - Facilities

Provider locations

Premier Substance Abuse Outpatient Child - Facilities



526 providers at 405 locations

- Single provider locations (152)
- Multiple provider locations (253)

☐ 30 mile radius

GeoAccess®

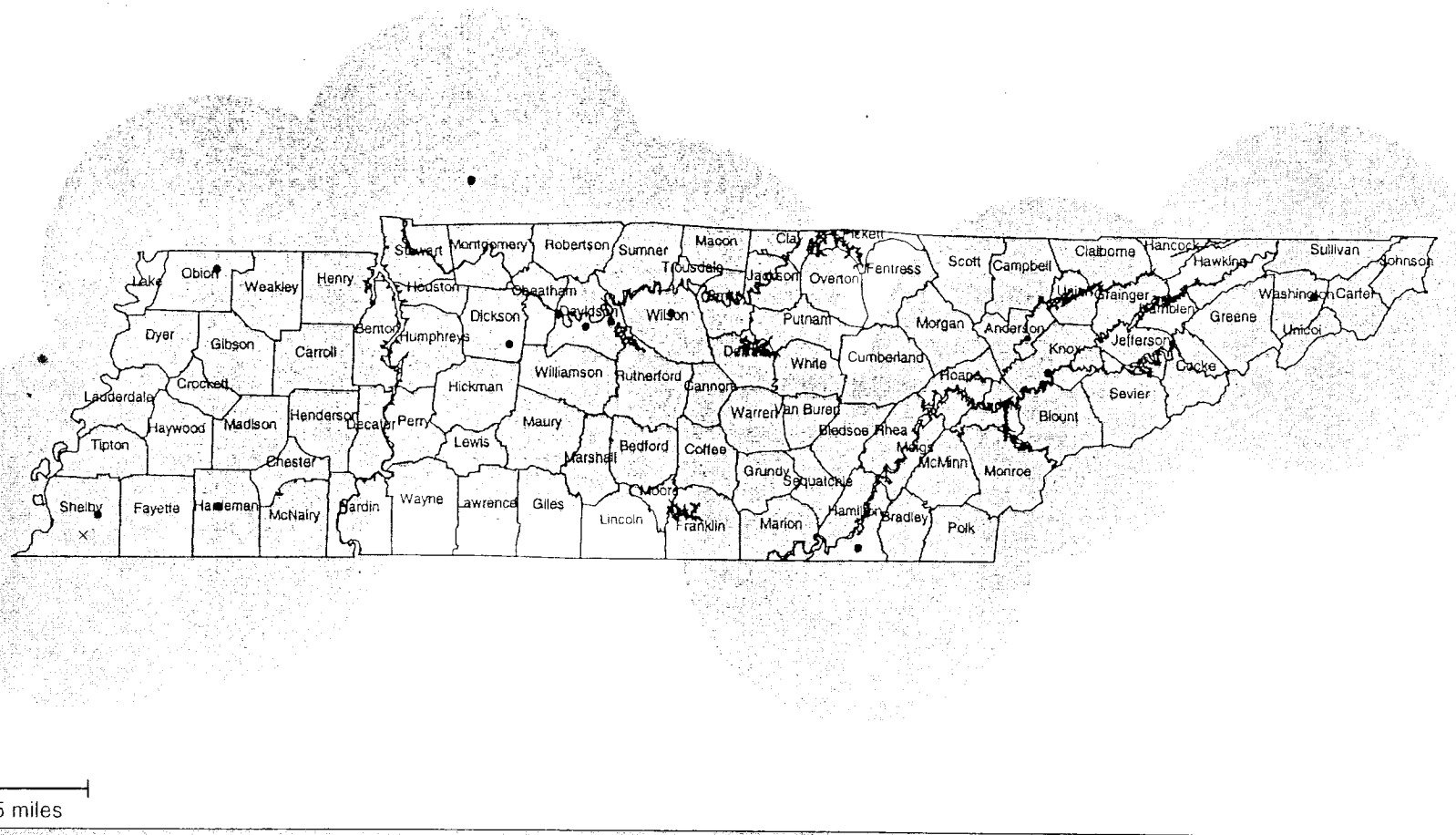
ZIP Code detail information

Premier Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
NO MEMBERS MEET THE SPECIFICATIONS			

Provider group: Premier Substance Abuse Outpatient Child - Facilities

Provider locations

TBH Inpatient Child - Facilities



15 providers at 15 locations

- ● Single provider locations (13)
- × Multiple provider locations (2)
- ☐ 60 mile radius

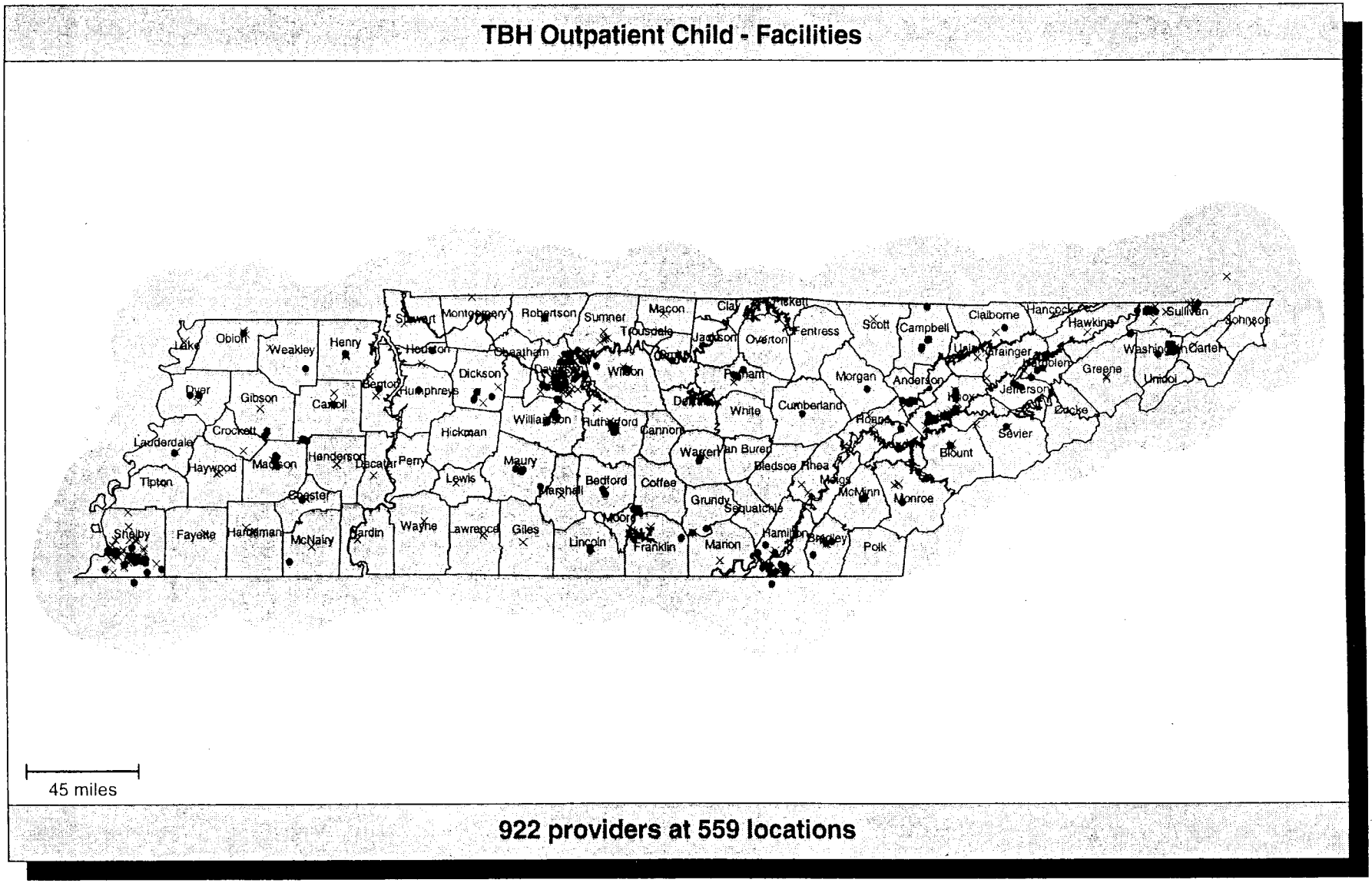
ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
FENTRESS - TN			
JAMESTOWN	38556	4	71.3
FRANKLIN - TN			
HUNTLAND	37345	3	65.0
GILES - TN			
GOODSPRING	38460	1	66.6
HENDERSON - TN			
DARDEN	38328	51	64.1
LINCOLN - TN			
FAYETTEVILLE	37334	2	70.9
FLINTVILLE	37335	2	68.1
TOTALS		63	65.0

Provider group: TBH Inpatient Child - Facilities

Provider locations



- Single provider locations (223)
- × Multiple provider locations (336)
- ☐ 30 mile radius

ZIP Code detail information

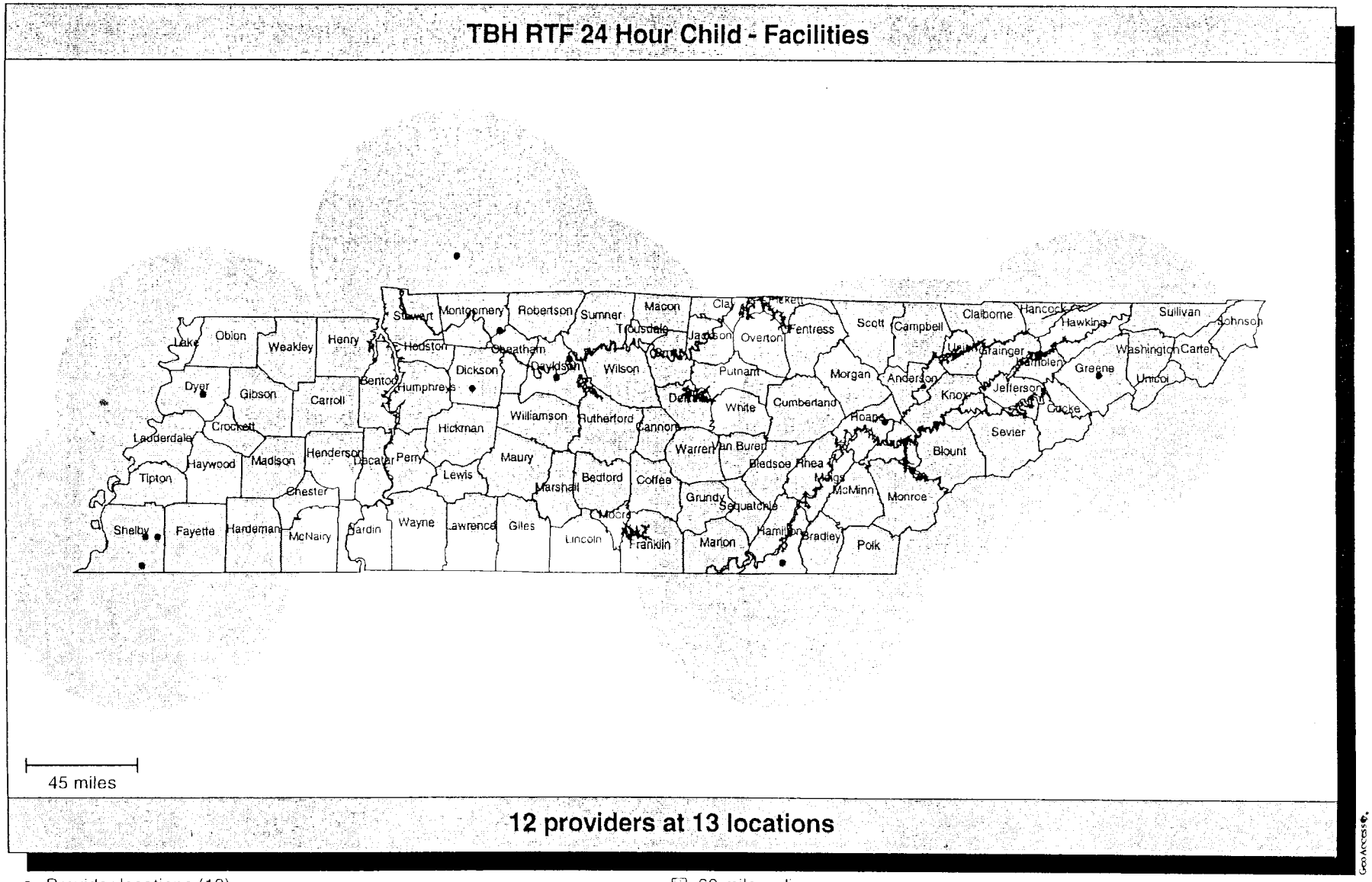
TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider

NO MEMBERS MEET THE SPECIFICATIONS

Provider group: TBH Outpatient Child - Facilities

Provider locations



● Provider locations (13)

▢ 60 mile radius

ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
CHESTER - TN			
ENVILLE	38332	83	76.1
HENDERSON	38340	743	65.5
JACKS CREEK	38347	59	72.3
LURAY	38352	42	66.2
COFFEE - TN			
MANCHESTER	37355	2	65.4
TULLAHOMA	37388	21	69.1
DECATUR - TN			
BATH SPRINGS	38311	41	69.8
DECATURVILLE	38329	213	65.6
FRANKLIN - TN			
HUNTLAND	37345	3	65.0
GILES - TN			
GOODSPRING	38460	1	71.6
PULASKI	38478	1	67.0
HARDIN - TN			
COUNCE	38326	104	84.4
CRUMP	38327	44	78.0
MORRIS CHAPEL	38361	85	79.8
OLIVEHILL	38475	84	76.7
PICKWICK DAM	38365	13	85.8
SALTILLO	38370	57	78.1
SAVANNAH	38372	1,679	83.3
SHILOH	38376	49	78.0
HENDERSON - TN			
LEXINGTON	38351	785	65.9
REAGAN	38368	140	74.7
SARDIS	38371	79	77.8
SCOTTS HILL	38374	137	71.6
JOHNSON - TN			
LAUREL BLOOMERY	37680	11	73.2
MOUNTAIN CITY	37683	76	68.6
SHADY VALLEY	37688	1	67.7
TRADE	37691	7	66.9
LINCOLN - TN			
FAYETTEVILLE	37334	2	71.3
FLINTVILLE	37335	2	68.1

GeoAccess®

Provider group: TBH RTF 24 Hour Child - Facilities

ZIP Code detail information

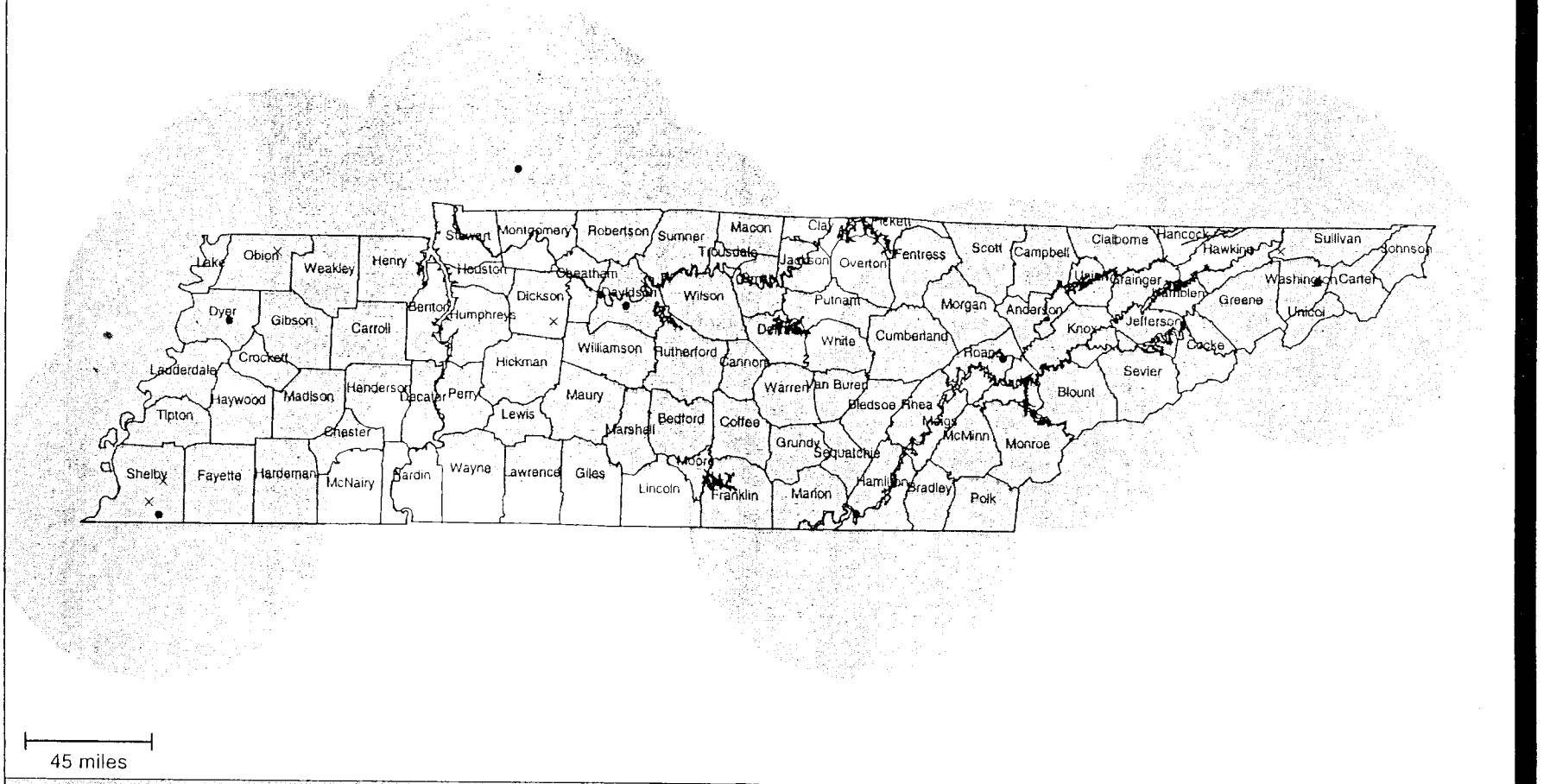
TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
MCNAIRY - TN			
ADAMSVILLE	38310	389	75.0
FINGER	38334	151	66.4
GUYS	38339	34	71.8
MICHIE	38357	153	77.9
MILLEDGEVILLE	38359	29	79.4
RAMER	38367	132	66.8
STANTONVILLE	38379	40	71.9
PUTNAM - TN			
COOKEVILLE	38506	1	68.8
VAN BUREN - TN			
ROCK ISLAND	38581	1	64.4
WARREN - TN			
MC MINNVILLE	37110	4	64.6
WAYNE - TN			
CLIFTON	38425	4	72.4
TOTALS		**5,502**	**74.3**

Provider group: TBH RTF 24 Hour Child - Facilities

Provider locations

TBH Substance Abuse Inpatient Child - Facilities



14 providers at 15 locations

- ● Single provider locations (8)
- × Multiple provider locations (7)
- ☐ 60 mile radius

ZIP Code detail information

TBH Child

County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
CHESTER - TN			
ENVILLE	38332	83	78.6
HENDERSON	38340	743	67.2
JACKS CREEK	38347	59	72.3
LURAY	38352	42	66.5
DECATUR - TN			
BATH SPRINGS	38311	41	73.6
DECATURVILLE	38329	213	69.8
GILES - TN			
GOODSPRING	38460	1	66.6
HARDIN - TN			
COUNCE	38326	104	86.8
CRUMP	38327	44	82.2
MORRIS CHAPEL	38361	85	84.4
OLIVEHILL	38475	84	80.0
PICKWICK DAM	38365	13	88.7
SALTILLO	38370	57	82.0
SAVANNAH	38372	1,679	87.8
SHILOH	38376	49	82.8
HENDERSON - TN			
DARDEN	38328	51	66.8
LEXINGTON	38351	785	66.2
REAGAN	38368	140	75.2
SARDIS	38371	79	81.5
SCOTTS HILL	38374	137	75.8
LINCOLN - TN			
FAYETTEVILLE	37334	2	71.8
MCNAIRY - TN			
ADAMSVILLE	38310	389	79.8
BETHEL SPRINGS	38315	261	66.3
FINGER	38334	151	71.0
GUYS	38339	34	73.3
MICHIE	38357	153	80.8
MILLEDGEVILLE	38359	29	83.0
RAMER	38367	132	69.9
SELMER	38375	514	67.5
STANTONVILLE	38379	40	76.7
PUTNAM - TN			
COOKEVILLE	38506	1	68.8

Provider group: TBH Substance Abuse Inpatient Child - Facilities

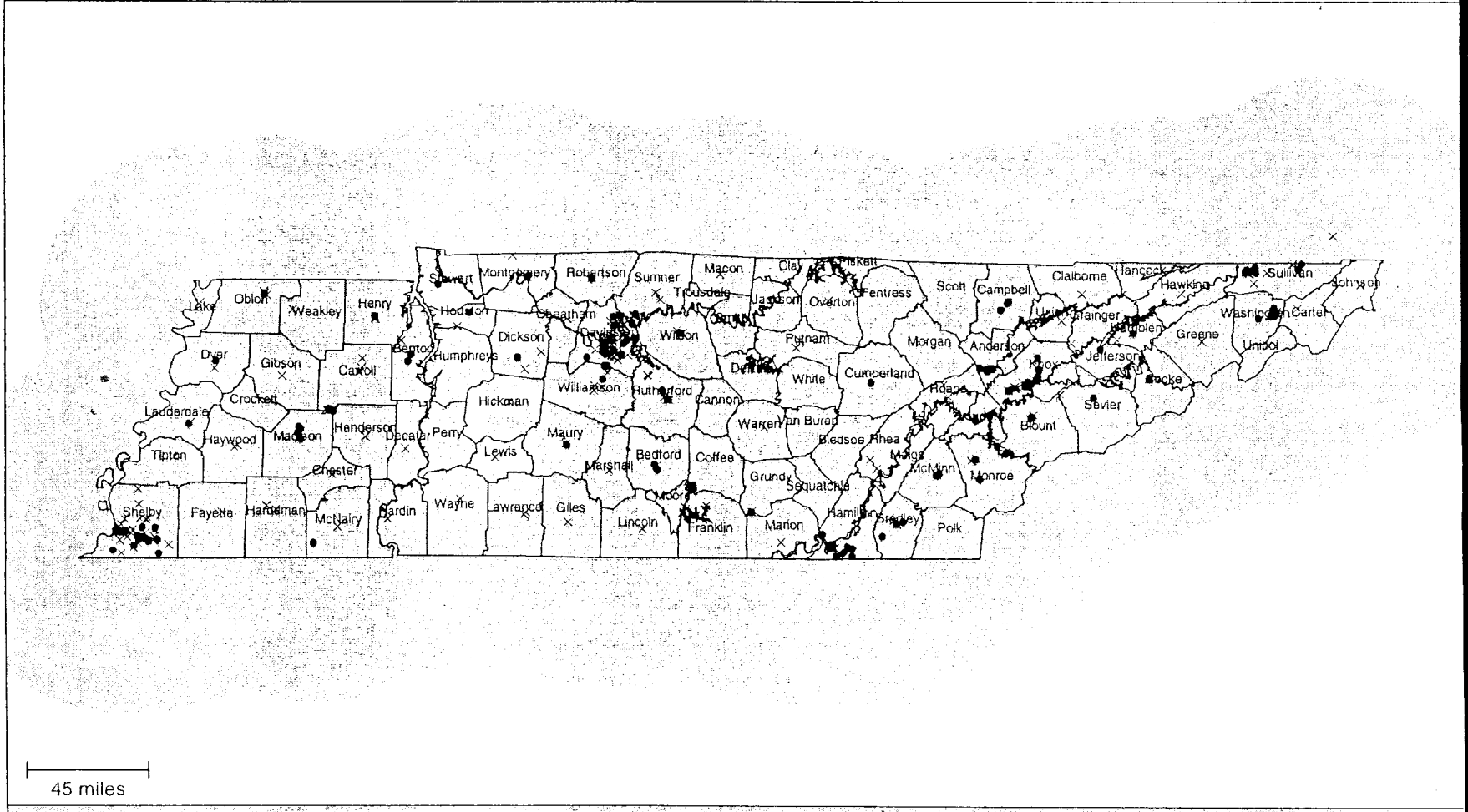
ZIP Code detail information

TBH Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
WAYNE - TN			
CLIFTON	38425	4	75.9
TOTALS		**6,199**	**76.1**

Provider group: TBH Substance Abuse Inpatient Child - Facilities

Provider locations

TBH Substance Abuse Outpatient Child - Facilities



45 miles

526 providers at 405 locations

- ● Single provider locations (152)
- × Multiple provider locations (253)
- ☐ 60 mile radius

ZIP Code detail information

TBH Child			
County/City	ZIP Code	Total number of Members	Average distance to a choice of 1 provider
NO MEMBERS MEET THE SPECIFICATIONS			

Provider group: TBH Substance Abuse Outpatient Child - Facilities

Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

John B. Progress Report
August 1, 2002 to January 31, 2003

TNAAP John B. Progress Report
August 1, 2002 to January 31, 2003

A new contract between the Bureau of TennCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) was executed for the period July 1, 2002 through June 30, 2003, and collaboration between TNAAP and the state continues.

The following provides an overview of activities under the contract between July 1, 2002 and January 31, 2003.

Representation on EPSDT cross-functional committees

TNAAP representatives meet with TennCare representatives monthly. TNAAP's EPSDT Director continues to participate in various committees and work groups such as the TennCare EPSDT Work Group (chaired by the TennCare Medical Director), the MCO Medical Director's meeting, and the TennCare and Children Work Group. In addition, Dr. Joel Bradley participates in the EPSDT Work Group and the MCO Medical Director's meetings, and Dr. Pat Davis has participated in the quarterly videoconferences sponsored by Tennessee Health Care Campaign.

Advice on issues related to coding, billing and documentation of EPSDT services

Dialogue between TNAAP and the State continues regarding appropriate coding and billing practices. In recent months, topics of conversation have included TB screening, newborn preventive health services and lab charges. There has also been both general and specific discussion regarding payment problems with individual MCOs. Discussions continue about appropriate documentation, most recently including providing feedback to the TennCare Quality Oversight Department about appropriate guidelines to be monitored with respect to hearing and vision screening.

TNAAP's EPSDT documentation forms were finalized and posted on TNAAP's web site in October. Updated versions of these forms were also forwarded to TennCare for posting on their web site and shared with the MCOs through the EPSDT work group. TNAAP distributed the forms at the TNAAP Open Forum and Pediatric Emergency Conferences held in Knoxville on September 13, and 14. Forms were also made available at TNAAP's Practice Manager Network training session on November 15, 2002. Further dissemination of the forms will occur as outlined in *Attachment I.*

Advice on the TennCare audit processes

The TennCare Oversight Department began scheduling audits in middle TN in early January. An audit was scheduled for January 23, 2003 with Columbia Pediatrics (the office of Pat Davis, MD, TNAAP's EPSDT Medical Director). State auditors cancelled the audit that morning due to snow and the audit is currently being rescheduled. An audit with another TNAAP member, Dr. James Hanley, MD, is scheduled for February

18, 2003. TNAAP staff and a member physician will be present during the audits and TNAAP will provide feedback about the audit process.

Development and implementation of training programs

TNAAP and the Office of the Children's Health Initiative established an educational advisory committee to oversee the educational activities of TNAAP and Cyber CE. This committee includes representation from TNAAP, two academic medical centers, The Tennessee Association of Family Physicians (TAFP) and a Pediatric Practice Manager. This committee had their initial meeting in November. The committee reviewed and provided feedback on draft educational materials prepared by TNAAP for distribution to physician offices by TNAAP's Coding Educator. Cyber CE presented an on-line presentation of Cyber CE's proposed EPSDT web site.

TNAAP is currently revising our educational materials to incorporate the feedback from this meeting. TNAAP has also developed an alternate web site model, which we feel may be informative and user-friendly. *See Attachment II* for a sample of the educational materials and TNAAP's web site draft. TNAAP's EPSDT Director met with staff of Cyber CE in December and shared TNAAP's web site recommendations.

Dr. Joel Bradley provided a coding training session for the EPSDT Work Group on January 13, 2003.

TNAAP hired a coding educator, Jacque Clouse, RHIT, CCP, who will begin work with TNAAP February 3, 2003. TNAAP did not fill the position for the original targeted effective date of October 1, 2002. Obstacles to filling the position included candidate's concerns about one of three factors. Those factors included concerns about the amount of travel, the pay rate, and the fact that the position is funded through a state contract (often perceived as not very stable particularly in a time of changing administrations). Fortunately, two very qualified candidates were identified and interviewed in December and January and a selection was made. For details about TNAAP's recruiting efforts see *Attachment III.*

TNAAP is continuing to disseminate the EPSDT video and other educational materials previously developed. The EPSDT Director has begun making physician office visits to distribute information about EPSDT and introduce the concept of the Coding Educator. The EPSDT Director has also established dialogue with Vanderbilt University Medical Center's Pediatric Residency Program and UT Knoxville's Family Practice Residency Program regarding working together on improving EPSDT residency training programs.

EPSDT newsletter articles appeared in the winter edition of the TNAAP newsletter. These topics include:

- EPSDT forms posted on web site
- A table obtained from TennCare that compares the benefit package for TennCare through 12/31/02 to the new TennCare Medicaid and TennCare Standard benefit packages effective January 1, 2003.

- An article prepared in cooperation with DCS regarding problems in obtaining EPSDT screens for Children in State custody
- An article regarding the EPSDT chart documentation forms, why practices should use them and where to obtain the most current versions of the forms.

See *Attachment IV* for sample newsletters (the Spring newsletter included numerous EPSDT related articles as well and a copy of this issue is also included).

Serve as a liaison with other professional organizations

TNAAP has continued dialogue with the TAFP regarding EPSDT services. An EPSDT newsletter article was forwarded for their information and use in their newsletter upon their discretion. TNAAP worked with TAFP to get a Family Practice representative on the Educational Advisory Committee and one of their Board members (Alan Wallstedt, MD) was named to that committee. Dr. David Kalwinsky, MD, TNAAP Vice President, participated in a TAFP Board meeting on October 31, 2002.

Establish a point person to work with TDH

TNAAP's EPSDT Director continued to work with the state's MCH Consultant for the Bureau of Health Services (Annette Goodrum) to work together on resolution of issues related to EPSDT screening between pediatricians and health departments.

Assist TennCare in Identifying Barriers to Delivery of EPSDT Services

A significant portion of the discussion at monthly meetings includes dialogue about barriers to the delivery of care for children. Problems recruiting and retaining pediatricians and other primary care physicians are primarily attributed to poor reimbursement and "hassle factors". One of the significant hassle factors relates to the multiple drug formularies used by the TennCare MCOs. TNAAP has had lengthy dialogue with various TennCare representatives about the need for a common pediatric formulary. For more information on TNAAP efforts and suggestions on this topic please refer to *Attachment V*.

TNAAP has also provided much input about problems with reimbursement and other "hassles". More detail is available upon request.

Assist with implementation of Screening Guidelines

There has been much discussion in our dialogue regarding the new developmental and behavioral screening guidelines scheduled for implementation some time in 2003. A TNAAP member piloted the forms in her office and provided specific feedback. Multiple TNAAP members have expressed deep concern about the practicality of implementing these new tools in the current environment. It is the opinion of TNAAP leaders that the additional cost and time required to utilize the tools will not be well received in the provider community if reimbursement is not adjusted. In addition, pediatricians are concerned about the lack of participating behavioral providers to treat children who may be identified. TennCare and TNAAP representatives have agreed to work together on

pilots in practices in each of the grand regions during the first half of 2003. There is also ongoing discussion regarding reconvening the screening guidelines committee to discuss this issue.

Collaborative efforts between the State and TNAAP continue to improve access to EPSDT services and appropriate documentation of those services.

Attachment I
Distribution of EPSDT Forms

TNAAP EPSDT Forms

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) has developed EPSDT documentation forms for use in physician offices. These forms were developed with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division. Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

The forms will be distributed to providers as follows:

	Action	Status
1	TNAAP will mail members a copy of the forms and notify them they will also be posted on the web site.	*
2	TNAAP will distribute the forms to the MCOs and will encourage their use of the forms.	Complete
3	The forms will be posted on the TNAAP web site.	Complete
4	The forms will be posted on the TennCare web site.	Complete
5	TNAAP will do a newsletter article about the forms and explain that they are posted on the web site.	Complete
6	TNAAP will contact TAFP and ask them to run the article or a similar announcement.	*
7	TNAAP will contact TMA and ask them to run the article or a similar announcement.	*
8	TNAAP will promote and distribute the forms through office visits, professional meetings and educational programs.	Currently being distributed
9	TNAAP will ask CYBER CE to promote the forms in their on-line sessions and any other educational initiatives they may be involved in.	*
10	The TennCare Quality Oversight Dept. will promote and distribute copies of the forms throughout the audit process.	Currently being distributed

These actions were on hold pending a final decision by the CHI Committee about adding the TNAAP logo to the form. The decision was made to add the logo at the November CHI Meeting. Once logo has been incorporated, further distribution will begin.

01/23/03

Attachment II
Draft Educational Materials and Web Site

Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

EPSDT Overview – DRAFT

December 2002

DRAFT

TNAAP
P.O. Box 159201
Nashville, TN 37215-9201
www.tnaap.org

Ruth E. Allen
TNAAP EPSDT Director
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Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

EPSDT Overview – DRAFT

DRAFT

Table of Contents

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DRAFT

EPSDT – What is it?
And Why You Should Care

Per Educational Advisory Committee
Insert page here describing current situation in TN

Include:

- Medicaid requirements
- TN current and target screening rates
- Some sort of explanation of John B. vs. Menke lawsuit and EPSDT compliance rates that were agreed to.

DRAFT

Definition of EPSDT

E Early

P Periodic

S Screening

D Diagnosis

T Treatment

Early – Assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic – Assessing a child's health at key points in his/her life to assure continued healthy development;

Screening – Using tests and procedures to determine if children being examined have conditions requiring closer medical/mental health or dental attention;

Diagnosis – Determining the nature and cause of conditions identified by screenings and those that require further attention; and

Treatment - Providing services needed to control, correct, or reduce physical and mental problems.

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Reimbursement for EPSDT Services

TennCare reimbursement for well child screens may be better than you expect. TennCare pays for services often not compensated for under private insurance. In most cases TennCare MCOs pay separately for each of the services listed below.

EPSDT Screening Services

Service
Evaluation and management code
Hearing Screen
Vision Screen
Vaccine Administration fee
Hemoglobin Test
Urine Test
Developmental/Behavioral Screen

Rev. 12/06/02 rea

DRAFT

Insert EPSDT Frequency Table here

TNAAP
Components of EPSDT Exam
History and Physical

DRAFT

Initial and Interval History - The comprehensive health history must be obtained from an interview with the parent/guardian or through a form or checklist completed by the parent/guardian. The history must contain, but not limited to, the following: • Present health status and past health history of recipient • Developmental information • Allergies and immunization history • Family history • Dietary history • Age appropriate social history • Current medication(s). **Documentation** - Once the health history is recorded in the medical record, only an update is required for subsequent visits.	**Developmental/Behavioral History** - Age-specific developmental milestones must be assessed at each preventive visit. Developmental/behavioral screening is an ongoing process that is most effectively performed using standardized validated screening tools. The tools recommended for use by the TennCare Screening Guidelines Committee can be located on the State's Web-site at http://www.state.tn.us/tenncare/CaringforKidsdev.html. If findings appear abnormal, the child should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment. **Documentation**- Results of the developmental/behavioral screenings must be documented in the medical record with a copy of the questionnaire and checklist included. Results and referrals must also be documented in the medical record.
Physical Exam -The physical examination must be performed with the child unclothed, but appropriately draped. This process can reveal obvious physical defects including nutritional abnormalities, orthopedic disorders, hernia, skin disease and/or genital abnormalities. The measurements in the column to the right are required. **Documentation** -Measurements in numerical values are to be recorded in the medical record at every visit. The head circumference, height, and weight should also be plotted on an age-appropriate growth chart available from the Centers for Disease Control website at www.cdc.gov/nchs.	Head circumference Head Circumference should be measured with a tape measure at each visit during the first two (2) years of life. Height Height should be measured at each visit. The height for infants up to two (2) years should be measured as recumbent length using a properly constructed measuring device. Height measurements for children over two (2) years of age should be accomplished using vertical measuring board or fixed wall device. Weight Weight should be measured at each visit with the child nude or wearing an examination gown. Blood Pressure (B/P) B/P measurement should begin at the age of three (3) years unless there is a clinical indication to begin prior to that time. The B/P should be measured at each screening visit using an appropriately sized cuff.

TNAAP
Components of EPSDT Exam
Hearing and Vision Screening

DRAFT

Recommendations of the TennCare Caring for Kids Screening Guidelines Committee (1999):

HEARING SCREENING:

- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Newborn hearing screening is recommended for all newborn infants. As of January 1999, not all hospitals in the State have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003.
- Recommended testing intervals: The committee recommends an objective hearing screening test once in each of the following age ranges: 3-6, 10-13, 14-18. Screening should be conducted at the first visit during the above listed intervals at which the patient is cooperative.
- Acceptable methods of objective hearing screening include: conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

VISION SCREENING

- Recommended testing intervals:
    - The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. The procedures

should be conducted at the first visit during which the patient is cooperative.
    - The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18.
- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Sterotest at 40 cm (630 secs of arc).
- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling F, HOTV, Picture Tests, Allen Figures, LH Tests.
- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

For additional information on requirements of subjective and objective tests by age, please refer to the guidelines on the provider page of the TennCare web site at http://www.state.tn.us/tenncare/CaringforKidsguidelines.html

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TNAAP
Components of EPSDT Exam
Laboratory

Requirement

The following lab procedures or screenings should be conducted in accordance with the American Academy of Pediatrics' (AAP) Recommendations for Preventive Pediatric Health Care:

• *Hereditary/Metabolic Screening* • *Hematocrit/Hemoglobin* • *Urinalysis* • *Lead Screening and Testing*	• *Tuberculosis Screening and Testing* • *Cholesterol Screening* • *STDs* • *Pelvic Exam*

Documentation

The results of all laboratory tests must be documented in the medical record.

References/Resources

http://www.aap.org/policy/re9939.html

Hereditary/Metabolic Screening

Requirement

Tennessee State Law requires every newborn to be tested for metabolic/genetic defects that would result in mental retardation or physical dysfunction if not treated in a timely manner. The following tests are required:

• Phenylketonuria (PKU) • Hypothyroidism • Hemoglobinopathies	• Galactosemia • Congenital Adrenal Hyperplasia (CAH).

Documentation

Screening visits between birth and two months should be documented in the medical record by the provider, including the tests done and results received.

References/Resources

1. AAP Policy Statement on Newborn Screening (RE9632) - http://www.aap.org/policy/01565.html
2. Maternal and Child Health, Tennessee Department of Health's Newborn Screening Program - http://170.142.76.180/Mch/genetics.htm.

Hematocrit/Hemoglobin

Requirement

To reduce risk of developmental delays and behavioral disturbances associated with iron deficiencies, hematocrit and/or hemoglobin should be tested on:

• Children 9 months of age, • Adolescents 14 years of age,	• All menstruating adolescents, annually, and • Pregnant adolescents.

Documentation

Test results, as well as any further evaluation, treatment, counseling or referral must be documented in the medical record.

References/Resources

http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00051880.htm

Urinalysis

Requirement

Most infection-related renal damage occurs during infancy and early childhood. Timely identification of infection, appropriate treatment, detection of patients at risk for renal scarring, and prevention of recurrent infection can greatly reduce the risk of adverse outcomes.

A minimum of one (1) dip stick urinalysis for leukocytes must be performed:

• At 5 years of age, • At 16 years of age, and	• Annually for all sexually active male and female adolescents.

Documentation

Test results, as well as appropriate treatment and referral, if indicated, must be recorded in the medical record.

DRAFT

References/Resources

http://www.aap.org/policy/RE9939.html

Lead Screening and Testing

Requirement

Children enrolled in Medicaid have a greater chance of having elevated blood lead levels than other children have. Blood lead levels (BLLs) as low as 10 mcg/dL have been associated with harmful effects on children's learning and behavior. Very high BLL (70 mcg/dL) can cause devastating health consequences, including seizures, coma and death.

Health Care Financing Administration (HCFA), now called Centers for Medicare and Medicaid Services (CMS), recommends administration of a blood lead screening test for all children enrolled in Medicaid at ages 12 and 24 months; children who have not previously been screened should be tested at ages 36--72 months. Administrating a risk-assessment questionnaire instead of a blood lead test does not meet Medicaid requirements.

Once the initial BLL is performed, further testing may be required. If the results are:

• 10-19 mcg/dL, perform confirmatory venous BLL within 1 month. • 20-44 mcg/dL, perform a confirmatory venous BLL within 1 week. • 45-59 mcg/dL, perform a confirmatory venous BLL within 48 hours.	• 60-69 mcg/dL, perform a confirmatory venous BLL with 24 hours. • >69 mcg/dL (urgent condition requiring hospitalization), perform immediately as an emergency lab test.

Documentation

The medical record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should also be documented in the medical record.

References/Resources

http://www.aap.org/policy/re9815.html.
http://www.state.tn.us/health/lead/professionals.htm
http://www.phppo.cdc.gov/cdcrecommends/showarticle.asp?a_artid=P0000975&TopNum=50&CallPg=Adv
http://www.state.tn.us/tenncare/pdf/tsop36-3.pdf

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TNAAP
Components of EPSDT Exam
Immunizations

Requirement

By ensuring that children are immunized on time, we can provide the best available defense against many dangerous childhood diseases. Immunizations protect children against: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), haemophilus influenza type b, chickenpox, pneumococcal and others.

Immunizations, if needed, should be given at the time of the EPSDT screening exam or at any other contact with the child. See the *Recommended Childhood Immunization Schedule* approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) regarding recommended ages for routine administration of currently licensed childhood vaccines.

Documentation

All immunizations must be documented in the medical record indicating type, lot number, date and signature, as well as any adverse reactions. If immunizations have been given at another facility, a copy of that record should be retrieved for the current record.

Billing

Immunizations given to adolescents 19 and 20 years of age should be billed using the appropriate CPT administration and serum codes. Immunizations given to children and adolescents aged 0-18 years fall under the Vaccines for Children (VFC) billing guidelines.

You are eligible to receive free vaccine serums from the Tennessee Dpeartment of Health's VFC Program. To enroll, contact the Tennessee Department of Health at 615-532-8513.

References/Resources

http://www.cdc.gov/nip
http://www.cdc.gov/nip/recs/child-schedule.htm#Printable
http://www.immunize.org/catg.d/p4060scr.pdf
http://www.immunize.org/catg.d/p2022b.pdf

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TNAAP
Components of EPSDT Exam
Health Education/Anticapatory Guidance

Requirement

Anticipatory guidance and health education are an integral part of the screening and must be provided by the health care professional. Age appropriate topics/information must be presented during each screening. The AAP recommends, at a minimum, that the following topics be addressed at each visit:

1. Injury Prevention
2. Violence Prevention
3. Sleep Positioning Counseling
4. Nutrition Counseling

Providers should use oral or written information.

Documentation

Specific topics addressed must be documented in the medical record. If age appropriate documentation forms are used, simply checking the items that apply is all that is necessary; however, any and all documentation should be dated and signed appropriately.

References/Resources

http://www.brightfutures.org/anticipatory/index.html
http://www.aap.org/family/tippmain.htm
http://www.aap.org/policy/re9832.html
http://www.aap.org/policy/re9946.html
http://www.brightfutures.org/nutrition/index.html

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TNAAP
Components of EPSDT Exam
Dental Referrals

This page is currently under revision

DRAFT

TNAAP
KEY EPSDT Codes

Preventive Medicine Codes

99381 New patient, under 1 year of age
99382 New patient, 1 – 4 years of age
99383 New patient, 5 – 11 years of age
99384 New patient, 12 – 17 years of age
99385 New patient, 18 – 21 years of age
99391 Established patient, under 1 year of age
99392 Established patient, 1 – 4 years of age
99393 Established patient, 5 – 11 years of age
99394 Established patient, 12 – 17 years of age
99395 Established patient, 18 – 21 years of age

Newborn Care

99431 History and physical exam
99432 Normal newborn care
99435 History and physical exam (assessed and discharged same day)

Developmental Testing

96110 Limited developmental testing and screening
96111 Extensive developmental testing

Laboratory Tests

85018 Hemoglobin
85013 Hematocrit
83655 Blood lead test
82465 Cholesterol
36406 Venipuncture, under 3 years of age
36410 Venipuncture, over 3 years of age requiring MD
36415 Routine venipuncture, including finger or heel stick
81000 Dipstick UA with microscopy
81001 Automated UA with microscopy
81002 Dipstick UA without microscopy
81003 Automated UA without microscopy

Hearing Screening

92506 Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92551 Screening test, pure tone, air only
92552 Pure tone audiometry, threshold, air only
92553 Pure tone audiometry, threshold, air and bone

Vision Screening

99172 Automated or semi-automated, quantitative exam, e.g. Snellen on a machine
99173 Quantitative visual acuity exam, e.g. Snellen chart on the wall

CPT Modifiers

-25 Significant separately indentifiable evaluation and management service by same physician on same day of procedure of other service
-90 Reference lab performed procedure, e.g. sending out a blood lead test
-91 Repeat lab test on same visit, e.g. confirmatory hemoglobin

ICD-9 Codes (Diagnosis)

V20.2 Routine infant or well child check
Newborn care
Premature infant

Immunizations (see back)

Immunizations 90471 Vaccine administration code, one injection 90472 Vaccine administration code, more than one injection, code for each subsequent injection (requires 90471 code) 90633 Hepatitis A, child or adolescent, 2 dose 90634 Hepatitis A, child or adolescent, 3 dose 90645 HIB, HbOC conjugate, 4 dose 90646 HIB, PRP-D conjugate, booster only 90647 HIB, PRP-OMP conjugate, 3 dose 90648 HIB, PRP-T conjugate, 4 dose 90669 Pneumococcal vaccine, polyvalent, under 5 years of age 90700 DTaP 90701 DTP 90707 MMR 90712 Oral Polio Vaccine (OPV) 90713 Intramuscular Polio Vaccine (IPV) 90716 Varicella vaccine 90718 Tetanus and diphtheria (Td), over 7 years of age 90720 DTP-Hib 90721 DTaP-Hib 90723 DTaP-Hepatitis B-IPV 90733 Meningococcal vaccine 90744 Hepatitis B, child or adolescent, 3 dose schedule	

BUREAU OF TENNCARE
DIVISION OF QUALITY OVERSIGHT
EPSDT AUDIT TOOL – 0-20 YEARS OLD

Name_____ ID#_____

Age_____ D.O.B. _____ MCO _____

Provider_____ DOS_____

Reviewer:

I. HISTORY	YES ☐	NO ☐	
Past	YES ☐	NO ☐	
Family	YES ☐	NO ☐	
Interval	YES ☐	NO ☐	NA ☐
Developmental /Behavioral Assessment	YES ☐	NO ☐	
Nutritional Assessment	YES ☐	NO ☐	
Lead Risk Assessment (6 mos. thru 72 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Risk Assessment (Begins at 2 years)	YES ☐	NO ☐	NA ☐

II. COMPREHENSIVE UNCLOTHED PHYSICAL	YES ☐	NO ☐	
Exam	YES ☐	NO ☐	
Weight	YES ☐	NO ☐	
Height	YES ☐	NO ☐	
Blood Pressure (Begins @ 3 yrs.)	YES ☐	NO ☐	NA ☐
Head Circumference (thru 24 mos.)	YES ☐	NO ☐	NA ☐
Pelvic Exam (If indicated)	YES ☐	NO ☐	NA ☐
Developmental Screening/Assessment	YES ☐	NO ☐	

III. LABORATORY TEST	YES ☐	NO ☐	
Newborn Panel	YES ☐	NO ☐	NA ☐
Hemoglobin or Hematocrit (9 mos. & 11-20 yrs.)	YES ☐	NO ☐	NA ☐
Urinalysis (5 yrs. & 11 - 20 yrs.)	YES ☐	NO ☐	NA ☐
Lead Screen (12 mos. & 24 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Test (If Indicated)	YES ☐	NO ☐	NA ☐
TB Test (If Indicated)	YES ☐	NO ☐	NA ☐
STD Screening (If Indicated)	YES ☐	NO ☐	NA ☐
Lead Screen Due to High Risk Assessment	YES ☐	NO ☐	NA ☐

IV. HEALTH EDUCATION	YES ☐	NO ☐

V. VISION	YES ☐	NO ☐

VI. HEARING	YES ☐	NO ☐

VII. DENTAL REFERRAL	YES ☐	NO ☐	NA ☐

EPSDT AUDIT TOOL 0-20 YEARS

IMMUNIZATIONS Up To Date	YES ☐	NO ☐			
	YES	NO	NA	CONTRAINDICATION	COMMENTS, REASONS IMMUNIZATIONS NOT GIVEN
Hepatitis B					
Diphtheria, Tetanus, Pertussis					
H. Influenza Type B					
Polio					
Measles, Mumps, Rubella					
Varicella Zoster					
Hepatitis A					

REFERRALS							
Miscellaneous	☐	*ENT*	☐	*PT, OT, Speech, Hearing*	☐	*Orthopedist*	☐
Ophthalmologist	☐	*Cardiopulmonary*	☐	*Allergist*	☐	*Surgeon/Plastic Surgeon*	☐
Urologist/Nephrologist	☐	*Dermatologist*	☐	*Neurologist*	☐	*Gastrologist*	☐
Endocrinologist	☐	*Mental Health*	☐	*None*	☐	*OB/GYN*	☐
Tennessee Early Intervention System	☐	*School System*	☐				

I. HISTORY

I. HISTORY - INITIAL AND INTERVAL HISTORY

This comprehensive history may be obtained from interview of the parent or guardian or through a form or checklist completed by the parent or guardian. History must contain, but is not limited to:

- Present health status and past health history or recipient
- Developmental information
- Allergies
- Family history
- Dietary history
- Age appropriate social history
- Current medication(s)

Once the health history is recorded in the medical record, only an update is required for subsequent visits.

DEVELOPMENTAL/BEHAVIORAL SCREENING

Age specific developmental "milestones' must be assessed at each preventive visit.

If findings appear abnormal, these children should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment.

Results of developmental/behavioral screening must be documented in the medical record. (See Section: Developmental/Behavioral Survey Tools)

NUTRITIONAL ASSESSMENT

Refer to age appropriate standardized screening forms.

CHOLESTEROL SCREENING

Cholesterol Risk Assessments. (beginning at age two (2)) Should include information which identifies parent or grandparent with coronary or peripheral vascular disease below age 55, parent with elevated blood cholesterol, or child with risk factors for future coronary disease (physical inactivity, obesity, diabetes mellitus). (Refer to age appropriate standardized screening forms and periodicity schedule.)

LEAD SCREENING

Document if a lead risk assessment was completed. Assessment begins at 6 months and then occurs at every encounter afterwards through 12 months. As soon as a child is determined to be at high risk for lead, testing must be completed. If a child is at low risk, then testing must be done at 12 months of age and again at 24 months. Lead assessment and testing would be found in physician's notes, immunization record, or lab reports.

The medical record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should be documented in the medical record. Refer to age appropriate standardized screening form section and Lead Screening Assessment.

II. COMPREHENSIVE UNCLOTHED PHYSICAL

The physical examination must be performed with the child unclothed but suitably draped. A comprehensive physical examination must be completed, including an examination of the heart with a stethoscope. Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including nutritional abnormalities, orthopedic disorders, hernia, skin disease, and genital abnormalities.
The following measurements are very important during the developmental years and should be recorded and compared to those considered normal for the same age.

MEASUREMENTS

The **Head** circumference should be measured with a tape measure at each visit during the first two years of life.

The **Height** should be measured with each visit.

The **Weight** should be measured at all ages. This may be found on growth charts or in physician documentation.

BLOOD PRESSURE (B/P) MONITORING

Should being at the age of three (3) years unless there is a clinical indication to being prior to that time. The B/P should be measured at each screening visit using an appropriate sized cuff.

PELVIC EXAMINATION

All sexually active adolescents or any female 18 or older should be screened annually for cervical cancer by use of a Pap test. Adolescents with a positive Pap test should be referred for further diagnostic assessment and management. (Refer to age appropriate standardized screening forms and STD/Pelvic Section)

Document findings on pelvic examination as well as Pap results must be documented in the medical record. Referral(s), if indicated, must be documented as well.

Document whether the PE was complete. To be complete it must include an unclothed assessment of all of the following: skin/nodes, head, neck, eyes, ears, nose, throat/mouth, heart, lungs, abdomen, genitalia, extremities/hips, spine and neurological functioning. Look for this information in well-child visit documentation.

III. LABORATORY TEST

NEWBORN METABOLIC SCREENING

The Tennessee State law requires that every newborn be tested for metabolic/genetic defects that would result in mental retardation or physical dysfunction if not treated in a timely manner. The following tests are required:

- Phenylketonuria
- Hypothyroidism
- Hemoglobinopathies
- Galactosemia

These tests are generally done while the infant is still in the hospital nursery. However, there may be instances when this is not done (ex. Infants born at home). The PCP must ensure that these tests have been done in a timely manner. If discrepancies are found, the provider should notify the local Health Department.

On screening visits between birth and two months, the provider should document that testing has been completed, as well as test results. (Refer to age appropriate Standardized Screening Form and Lab section).

HEMATOCRIT OR HEMOGLOBIN (Hct./Hgb.)

Hgb. And 11ci. Screening should be done at or by ages 9 months and 15 years. Annual Hct. Or High screen should be done on females presenting with the following:

- Moderate to heavy menses
- Chronic weight loss
- Nutritional deficit
- Athletic activity

Document if a hemoglobin/hematocrit was obtained. It may be noted as PCV, and it may be found in physician documentation or in a lab report. (Refer to age appropriate standardized screening form and lab section)

URINE TESTING

Most infection-related renal damage occurs during infancy and early childhood. Timely identification of infection, appropriate treatment, detection of patients at risk for renal scarring, and prevention of recurrent infection can greatly reduce the risk of an adverse outcome.

A minimum of one (1) dip stick urine must be performed at five (5) years of age.

Documentation of test results, as well as appropriate treatment and referral, if indicated, must be recorded in the medical record. (Refer to age appropriate standardized form and lab section)

TUBERCULIN TEST

TB test may be found on immunization sheet.

The TB Risk Assessment Questionnaire should be completed beginning at age 12 months and at each screening thereafter, in order to determine risk. For high-risk groups, the Committee on Infectious Disease recommends TB skin testing immediately and every 1-3 years.

TB skin test should be read and documented by a health professional. The Health Department must be notified of any high-risk child or any positive skin test reading.

Documentation:

The administration of the tuberculin skin test and the results must be recorded in the medical record with appropriate dates and signatures. Treatment and/or referral must also be documented in the medical record.

(Refer to age appropriate standardized screening form and assessment section)

CHOLESTEROL TESTING

Optional cholesterol testing by practicing physicians may be appropriate for children who are judged to be at higher risk for coronary heart disease independent of family history. For example, adolescents who smoke, consume excessive amount of saturated fats and cholesterol, or are overweight may also be tested at the discretion of their PCP. For parents who do not know their cholesterol levels, PCPs should strongly encourage them to have their levels measured. (Refer to age appropriate standardized screening form and assessment section)

LEAD TESTING

Children enrolled in Medicaid have a greater chance of having elevated blood lead levels than other children. Blood lead levels (BLLs) as low as 10 mcg/dL are associated with harmful effects on children's learning and behavior. Very high BLL ($\geq$70 mcg/dL) can cause devastating health consequences, including seizure, coma, and death.

Health Care Financing Administration (HCFA) policy calls for children enrolled in Medicaid (TennCare) to have their BLL measured at 12 and 24 months of age, while children are 36-72 months should be tested if they were missed earlier. (*State Medicaid Manual*, September 1998. Paragraph 513.2).

In children with screening BLL.10 mcg/dL, the first step is to perform a confirmatory venous BLL. This should be performed immediately if screening BLL>70 mcg/dL (urgent condition requiring hospitalization); within 48 hours if screening result is 45-69 mcg/dL; within 1 week if screening result is 20-44 mcg/dL; within 1 month if screening result is 10-19 mcg/dL.

Documentation:

The medication record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should be documented in the medical record. (Refer to age appropriate standardized screening form and assessment section)

SEXUALLY TRANSMITTED DISEASES (STDS)

Adolescence is a time of experimentation and risk taking. Developmentally, adolescents are at a crossroads of health. Emerging cognitive abilities and social experiences lead adolescents to question adult values and experiment with health risk behaviors. Some behaviors threaten current health, while others may have long-term health consequences.

All adolescents should be asked about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection. They should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDs , including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to properly use them. All sexually active adolescents should be screened annually for STDs or more often if deemed medically necessary.

STD screening and results must be documented in the medical record as well as education and treatment, if indicated. The local Health Department must be notified of all positive STDs.

Pap smear should be performed at age 18 and above. (Refer to age appropriate standardized screening form and STD/Pelvic section)

IV. HEALTH EDUCATION

ANTICIPATORY GUIDANCE/HEALTH EDUCATION

Anticipatory guidance and health education are an integral part of the screening and must be provided by the professional. Age appropriate topics/information must be presented during each screen. Providers should use oral and written information.

Specific topics discussed or written information distributed must be documented in the medical record. If the age appropriate encounter form is used, simply checking the items that apply is all that is necessary. However, any and all documentation should be dated and signed appropriately. (See Standardized Screening Forms for age appropriate health standards).

V. VISION

All children should have an eye exam using ophthalmoscope. In addition, all children should have additional vision screening that is age appropriate. This includes screening for ocular alignment, visual acuity and physical abnormalities of the eye.

(See age appropriate standardized screening forms and recommendations of TennCare EPSDT Screening Guidelines Committee and Screening Section)

The examination(s) performed and results should be recorded in the medical record. Referrals should be documented.

VI. HEARING

Significant hearing loss can be present at birth and, if undetected, will impede speech, language, and cognitive development. Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE).

Screening the hearing in infants and young children up to the age of three (3) may be accomplished using Denver noise makers, voice, etc., and subjectively by parental observation. Objective hearing measurements should be done as early as **age three years** and as indicated on the periodicity schedule. Bilateral audiometric screening should be done with pure tones of 20dB HL at 500, 1000, 2000 and 4000Hz.

Results of the screening must be recorded in the medical record indicating passed or failed. Positive screening results should lead to referral for diagnostic assessment of hearing. However, a prompt re-screening may be done prior to referral if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit. All screening and results must be documented in the medical record. (See age appropriate standardized screening form and Recommendations of TennCare EPSDT Screening Guidelines Comments).

VII. IMMUNIZATIONS

Immunizations, if needed should be given at the time of the preventive/checkup visit or at any other contract with the child.

See Recommended Childhood Immunization Schedule January - December 2000 from the American Academy of Pediatrics.

Hepatitis B may be documented as Hep. B or HBV.

Diphtheria, Tetanus and Pertussis may be documented as DTP, DTP-Hib, or DTAP-Hib, seen as Tetramune combo-which is DTP and Hib.

Hemophilus Influenza type b may be documented as Hib, DTP-Hib, or DTAP-Hib, seen as Tetramune combo-which is DTP an Hib.

Polio vaccine may be documented as OPV or IPV.

Measles, Mumps and Rubella vaccine may be documented as MMR.

Varicella Zoster vaccine may be recorded as chicken pox or Varivax. This vaccine was not mandatory until 6/30/97.

If any immunization is contraindicated at date of service, mark audit tool as contraindicated. (See age appropriate standardized screening from and Immunization Section). Mark tool N/A if immunization is not applicable at date of service.

DENTAL SCREENING

Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supportive structures. Maintenance of good dental health requires the beginning of dental care at an early age.

Although an oral screening is part of the physical examination, it does not substitute for screening examination performed by a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule. Children must be referred to a dentist for routine dental care beginning at age three (3) and yearly thereafter. However, if deemed medically necessary, a dental referral may be made at any age.

Dental inspection as well as referral and education must be documented in the medical record. (See age appropriate standardized screening form, periodicity schedule and Dental Section).

REFERRALS

Determine if the provider made any referrals for the child on the date of service and mark the appropriate box. If no referrals made please mark "none".

LEGIBILITY

Rate the legibility of the medical record according to the scale given.

Once chart audit has been completed, count all seven components and place appropriate numbers at top of audit tool.

TNAAP EPSDT Chart Documentation Forms

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) has developed EPSDT documentation forms for use in physician offices. These forms were developed with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division.

Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

Paper copies of the forms follow. Electronic copies of these forms can be obtained from the TNAAP web site at www.tnaap.org.

N B

EPSDT Screening Date ___/___/200___

Member ID # ___-___-____

Newborn Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ min. _____ times per day

☐ Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

Wet diapers per day _____

Strong stream (if male)? Yes No ?

Stools per day _____

WIC yes no

Problems

Constipation	Yes	No
Sleep	Yes	No
Spitting up	Yes	No
Excessive crying	Yes	No

_____

_____

_____

Hearing

Responds to sounds yes no

Newborn hearing screen:

NL Repeat not done

Vision:

Looks at parent's face yes no

Newborn Metabolic Screen

NL Repeat Pending

☐ See New Patient History Sheet

Physical Exam (undressed yes no) √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Umbilical Cord	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Circumcision	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Sleep on back
- ☐ Firm, well fitting crib mattress

Health

- ☐ ↑ feedings to 26 – 32 oz /day
- ☐ Sponge bathe
- ☐ Cord, circumcision care
- ☐ Bowel movements
- ☐ Fever

Social/Behavioral

- ☐ Who makes up family
- ☐ Support for mother
- ☐ Baby's temperament
- ☐ Cuddle, talk, rock
- ☐ Sleep

Impression

- ☐ Well Newborn
- ☐ Premature Infant
- ☐ Jaundice
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Hepatitis B #1
- ☐ RTC 1 month _____
- ☐ _____

_____

_____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID # _____

1 M | EPSDT Screening Date | / / 200 | Member ID # | – –

One Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ min. q. _____ hrs.

☐ Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Colic	yes	no
Stuffy nose	yes	no
Sleep	yes	no

_____

_____

_____

Hearing

Responds to sounds yes no

Newborn hearing screen:

NI Repeat Not done

Vision:

Looks at parent's face yes no

Follows with eyes yes no

Developmental Screen

see separate form

normal abnormal

Newborn Metabolic Screen

normal repeat pending

Physical Exam

undressed: yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Umbilical Cord	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Circumcision	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Sleep on back
- ☐ Crib Safety

Health/Nutrition

- ☐ If bottle fed, 26-32 oz/day
- ☐ If breast fed, nurses 8-10 times/day
- ☐ Delay solids
- ☐ Bowel movements
- ☐ Strong urinary stream, if male
- ☐ Fever

Social/Behavioral

- ☐ Temperament
- ☐ Sleep
- ☐ Talk to baby
- ☐ Support for mother
- ☐ Day care plans yes no

Impression

- ☐ Well Baby
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Hepatitis B Vaccine
- ☐ Vaccine Information Sheet
- ☐ One month Handout sheet
- ☐ RTC at 2 months _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID #

2 M EPSDT Screening Date ___/___/200 Member ID# ___-___-____

2 Month Visit

Name _____ Birth Date _____ Historian _____

ge _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

- ☐ Breast _____ times per day
- ☐ Formula _____ oz. per day

Brand _____
With iron? Yes No

- ☐ Cereal Yes No

Water: city well spring bottled
WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

_____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Colic	yes	no
Stuffy nose	yes	no
Sleep	yes	no
Diaper rash	yes	no

_____

_____

Hearing

Responds to sounds yes no
Smiles and laughs yes no
Newborn hearing screen:
normal Repeat Not done

Vision:

Looks at parent's face yes no
Follows with eyes yes no

Developmental Screen*

normal abnormal

Newborn Metabolic Screen

normal abnormal pending

*see separate form

Physical Exam

undressed: yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Spine	☐
Extremities	☐
Hips	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Sleep on back
- ☐ Crib safety
- ☐ Rolling over, prevent falls

Health/Nutrition

- ☐ If bottle fed, 26-32 oz/day
- ☐ If breast fed, nurses 8-10 times/day
- ☐ Delay solids
- ☐ Bowel movements
- ☐ Strong urinary stream, if male
- ☐ Fever

Social/Behavioral

- ☐ Temperament
- ☐ Sleep
- ☐ Talk to baby
- ☐ Support for mother
- ☐ Day care plans yes no

Impression

- ☐ Well Baby, nl. growth and development
- ☐ _____
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ DTaP, IPV, Hib, Hep B, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____ mg. q 4 hrs.
- ☐ Two month Handout sheet
- ☐ RTC at 4 months _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

- ☐ See back for additional documentation

Provider ID # _____

4 M

EPSDT Screening Date

/ / 2 0 0

Member ID #

4 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ times per day.

☐ Formula _____ oz. per day

Brand _____
With iron? Yes No

Water: city well spring bottled
Cereal/baby food Yes No
WIC: yes no

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems/Concerns

Spitting up	yes	no
Constipation	yes	no
Sleep	yes	no
Diaper rash	yes	no

_____

_____

Hearing/Speech

Responds to sounds	yes	no
Babbles and coos	yes	no

Vision:

Looks at parent's face	yes	no
Follows with eyes	yes	no

Developmental Screen*

normal abnormal

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing backwards
- ☐ Smoke free environment
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ No bottle propping
- ☐ Fall prevention
- ☐ Bath safety
- ☐ No baby walkers
- ☐ Child proof home

Health/Nutrition

- ☐ If bottle fed, 26-32 oz/day
- ☐ If breast fed, nurses 8-10 times/day
- ☐ Introduce solids
- ☐ Avoid honey
- ☐ Teething

Social/Behavioral

- ☐ Temperament
- ☐ Sleep, bedtime routine
- ☐ Talk, read to baby
- ☐ Family support
- ☐ Day care yes no

Impression

- ☐ Well Baby, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ DTaP, IPV, Hib, Hep B, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____ mg. q 4 hrs.
- ☐ Four month Handout sheet
- ☐ RTC at 6 months _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID#

6 M

EPSDT Screening Date ☐☐/☐☐/2 0 0☐

Member ID# ☐☐☐–☐☐–☐☐☐☐

6 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs._____oz. Length _____ inches Head circ. _____ cm Temp. _____T R

Nutrition

☐ Breast_____times per day.

☐ Formula _____oz . per day

Brand_____

With iron? Yes No

Water: city well spring bottled

Cereal/baby food Yes No

Servings per day _____

WIC: yes no

History Update

Are there any changes in your family history? No Yes

_____

Has the patient had any new problems or illnesses since the last visit?

No Yes

_____

Problems/Concerns

Constipation	yes	no
Sleep	yes	no
Diaper rash	yes	no

_____

Hearing/Speech

Responds to sounds	yes	no
Jabbers and laughs	yes	no

Vision:

Looks at parent's face	yes	no
Follows with eyes	yes	no

Developmental Screen*

normal abnormal

Lead Risk Factors*

yes no

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

☐ Car seat, facing backward
☐ Smoke detectors in home
☐ Hot water < 120 degrees
☐ Rolling over, fall prevention
☐ No baby walkers
☐ Child proof home
☐ Always supervise bath
☐ Sun exposure

Health/Nutrition

☐ Continue formula or breast milk
☐ Introduce meats, finger foods
☐ Introduce cup, juice
☐ Avoid honey
☐ Teething / clean teeth
☐ No bottle in bed or bottle propping

Social/Behavioral

☐ Temperament
☐ Sleep, bedtime routine
☐ Talk, read to baby
☐ Family support
☐ Day care yes no

Impression

☐ Well Baby, normal growth and development

☐ _____

☐ _____

Plan/Referrals

☐ DTaP, PCV-7, Hib, Hep B, IPV
☐ Vaccine Information Sheet
☐ Acetaminophen _____mg. q 4 hrs.
☐ Six month Handout sheet
☐ RTC at 9 months
☐ Fluoride gtts. 0.25 mg daily

☐ _____

☐ _____

☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ☐☐☐☐☐☐☐☐☐☐☐☐

9 M

EPSDT Screening Date ___/___/2000

Member ID# ___-___-____

9 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

☐ Breast _____ times per day.

☐ Formula _____ oz . per day

Brand _____

With iron? Yes No

Water: city well spring bottled

Baby food _____ servings/day

Table foods Yes No

WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Responds to sounds yes no

Imitates speech yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors*

yes no

Lab Tests

Hgb _____

_____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

☐ Car seat, facing backward
☐ Smoke detectors in home
☐ Smoke free environment
☐ Hot water < 120 degrees
☐ Fall prevention
☐ Child proof home
☐ Syrup of Ipecac, Poison Control #
☐ Always supervise bath
☐ Sun exposure

Health/Nutrition

☐ Continue formula or breast milk
☐ Introduce table, finger foods
☐ Choking prevention
☐ Avoid honey
☐ Introduce cup, weaning
☐ Teething / clean teeth
☐ No bottle in bed or bottle propping

Social/Behavioral

☐ Exploring; set consistent limits
☐ Sleep, bedtime routine
☐ Talk, read to baby
☐ Family
☐ Day care

Impression

☐ Well Baby, normal growth and development

☐ _____

☐ _____

Plan/Referrals

☐ Hep B, Hib, DPaT, IPV, PCV-7
☐ Vaccine Information Sheet
☐ Acetaminophen _____ mg. q 4 hrs.
☐ Nine month Handout sheet
☐ RTC at 12 months
☐ Fluoride gtts. 0.25 mg daily

☐ _____

☐ _____

☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ____________

1	2	M

EPSDT Screening Date Date | | | / | | | / | 2 | 0 | 0 | |

Member ID# | | | | – | | | – | | | | |

12 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 2-4 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb(if not done at 9 mo)_____

Lead level_____

_____

See separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward if > 20#
- ☐ Smoke detectors in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaning
- ☐ Introduce whole milk from cup
- ☐ Limit juice, milk intake
- ☐ Changes in appetite
- ☐ Introduce table, finger foods
- ☐ Choking prevention
- ☐ Teething / clean teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Sleep, bedtime routine
- ☐ Talk, read to baby
- ☐ Family
- ☐ Day care yes no

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Varicella, PCV-7, Hib, Hep B, DTaP, IPV, MMR
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Twelve month Handout sheet
- ☐ RTC at 15 months
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# | | | | | | | | | | | |

1 5 M

EPSDT Screening Date ☐☐/☐☐/200☐

Member ID# ☐☐☐-☐☐-☐☐☐☐

15 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 3-6 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb(if not done at 9 mo)_____

Lead level_____

_____

* separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward if > 20#
- ☐ Smoke detectors,no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaned from bottle?
- ☐ Whole milk until age two
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Offer variety of foods
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Sleep, bedtime routine
- ☐ Talk, read to child
- ☐ Family

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ MMR, Hib, DTaP,IPV, Varicella, PCV-7
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Fifteen month Handout sheet
- ☐ RTC at 18 months
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ☐☐☐☐☐☐☐☐☐☐☐☐

1	8	M

EPSDT Screening Date | | | / | | / | 2 | 0 | 0 |

Member ID# | | | | – | | | – | | | | |

18 Month Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Whole milk yes no
Weaned from bottle? yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Says 15-20 words yes no

Vision:

Notices small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests (record result from visits at 9-12 months, if done)

Hgb _____

ad level _____
see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Fontanel	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Hips/Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward
- ☐ Smoke detectors, no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Close supervision
- ☐ Sun exposure

Health/Nutrition

- ☐ Weaned from bottle?
- ☐ Whole milk until age two
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Offer variety of foods
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set consistent limits, discipline
- ☐ Praise good behavior
- ☐ Time out, tantrums
- ☐ Toilet training
- ☐ Talk, read to child
- ☐ Family
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ DTaP, IPV, Hib, Hep B, MMR , PCV-7, Var.
- ☐ Vaccine Information Sheet
- ☐ Acetaminophen _____mg. q 4 hrs.
- ☐ Eighteen month Handout sheet
- ☐ RTC at 2 years
- ☐ Fluoride gtts. 0.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# | | | | | | | | | | | |

2 Y EPSDT Screening Date ___/___/2000 Member ID# ___-___-____

Two Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ inches Head circ. _____ cm Temp. _____ T R

Nutrition

Weaned from bottle? yes no

Appetite: good variable picky

fruits _____

veggies _____

meats _____

bread _____

Water: city well spring bottled

WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Has the patient had any new problems or illnesses since the last visit?

Yes _____

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no

2-3 word sentences yes no

Vision:

Sees distant objects well? yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb _____

Lead level _____

(Hgb required at 9 mos. Test only if not done previously or if abnl. Lead level required at 12 & 24 mos. for TNCare.)

Cholesterol _____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car seat, facing forward
- ☐ Smoke detectors, no smoking in home
- ☐ Hot water < 120 degrees
- ☐ Child proof home, supervision
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk from cup
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Choking prevention
- ☐ Brushing teeth

Social/Behavioral

- ☐ Set limits, time out
- ☐ Praise good behavior
- ☐ TV limits
- ☐ Read to child
- ☐ Toilet training
- ☐ Sleep, bedtime routine
- ☐ Family
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ DTaP, IPV, HepB, HIB, MMR, Var, PCV-7
- ☐ Two year handout sheet
- ☐ RTC at 3 years
- ☐ Fluoride gtts. O.25 mg daily
- ☐ Vitamin Drops with Iron
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ____________

3 Y EPSDT Screening Date ___/___/2 0 0 ___ Member ID# ___-___-____

Three Year Visit

me _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____lbs Length _____ inches BP _____ Temp. _____T R O

Nutrition

Lowfat milk, cup only yes no
Appetite: good variable picky
fruits _____
veggies _____
meats _____
bread _____
Water: city well spring bottled
WIC: Yes No

History Update

Are there any changes in your family history?

No Yes _____

Has the patient had any new problems or illnesses since the last visit?

No Yes _____
FH heart disease < 55 No Yes
↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Hearing/Speech

Hears well ? yes no
Talks well ? yes no
Easy to understand ? yes no

Vision:

Sees small objects yes no

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb _____

Lead level _____
(Hgb required at 9 mos. Test only if not done previously or if abnl. Omit lead if normal at 24 months& low risk)

Cholesterol _____

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Car safety seat, back seat safest
- ☐ Smoke detectors, no smoking in home
- ☐ Syrup of Ipecac, Poison Control #
- ☐ Water safety, supervise bath
- ☐ Firearm safety
- ☐ Outdoor safety, supervision
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk from cup
- ☐ Limit juice, milk intake
- ☐ Picky appetites, self feeding
- ☐ Low fat foods and healthy snacks
- ☐ Brush teeth, see dentist

Social/Behavioral

- ☐ Discipline, time out
- ☐ Praise good behavior
- ☐ TV limits, read to child
- ☐ Toilet training
- ☐ Self help skills
- ☐ Curiosity about sex
- ☐ Family
- ☐ Friends and playmates
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ DTaP, IPV,HepB, Hib, MMR,Var, PCV-7
- ☐ Three year handout sheet
- ☐ RTC at 4 years
- ☐ Fluoride gtts. O.5 mg daily
- ☐ Chewable Vitamins with Iron
- ☐ Dental check-up
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ____

4 Y EPSDT Screening Date ___/___/200 Member ID# ___-___-____

Four Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T R O

History Update

Changes in your family history?
No Yes

_____

Has the patient had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Nutrition

Appetite: good variable picky
Water: city well spring bottled
WIC: Yes No

Hearing/Speech

Hears well ? yes no
Talks well ? yes no
Easy to understand ? yes no
Hearing screening test
normal abnormal unco-op

Vision:

Notices small objects yes no
Vision screening test:

L _____ R _____

Developmental Screen*

normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

IPPD result _____

Lab Tests

Hgb _____

Lead level _____
(Hgb required at 9 mos. Test only if not done previously or if abnl. Omit lead level normal at 24 mos. & low risk.)

Cholesterol _____
*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety

- ☐ Smoke detectors
- ☐ No smoking in home
- ☐ Car safety seat, back seat safest
- ☐ Booster seat > 40 #
- ☐ Bike helmet
- ☐ Water safety, swimming lessons
- ☐ Firearm safety
- ☐ Outdoor safety, supervision
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk
- ☐ Encourage fruits and vegetables
- ☐ Brush teeth, see dentist
- ☐ Encourage active play

Social/Behavioral

- ☐ Discipline, time out
- ☐ Praise good behavior
- ☐ TV limits, read to child
- ☐ Dresses self, helps at home
- ☐ Curiosity about sex
- ☐ Family
- ☐ Friends and playmates
- ☐ Day care, pre-school

Impression

- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ DTaP, IPV, HepB, Hib, MMR, Var
- ☐ Four year handout sheet
- ☐ RTC at 5 years
- ☐ Fluoride gtts. O.5 mg daily
- ☐ Chewable Vitamins with Iron
- ☐ See dentist
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# ___-___-____

5 Y EPSDT Screening Date ☐☐/☐☐/200☐ Member ID # ☐☐☐-☐☐-☐☐☐☐

FiveYear Preventive Visit and Kindergarten Check-up

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Height _____inches Weight _____ lbs. Blood pressure _____ Temp. _____T R O

History Update
Changes in family history? No Yes

_____
FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes
Has the patient had any new problems or illnesses since the last visit? No Yes

_____

Problems / Parental Concerns

_____

_____

Nutrition
Appetite: good variable picky
Water: city well spring bottled
WIC: Yes No

Hearing/Speech
Problems with speech? yes no
Hearing screen normal abnormal

Vision:
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____

Muscle balance pass fail

Developmental Screen*
normal abnormal

Lead Risk Factors* yes no

TB Risk Factors* yes no

TPPD result _____

Lab Tests
Hgb_____

Lead level _____ Omit lead level if normal at 24 mos. & low risk.
Cholesterol _____
Urinalysis (required at age five)
back for results
separate form

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Red reflex	☐
Alignment	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia	
Female	☐
Male	☐
Testes	☐
Extremities	☐
Gait	☐
Spine	☐
Skin	☐
Neuro	☐

Safety
- ☐ Smoke detectors, no smoking in home
- ☐ Booster seat > 40 #, < 70 #
- ☐ Bike helmet, street safety
- ☐ Water safety, swimming lessons
- ☐ Firearm safety
- ☐ Outdoor safety, supervision
- ☐ Sunburn prevention

Health/Nutrition
- ☐ Low fat milk
- ☐ Encourage fruits and vegetables
- ☐ Brush teeth, see dentist
- ☐ Encourage active play

Social/Behavioral
- ☐ Give choices, encourage independence
- ☐ Praise good behavior
- ☐ Talk, time out, lose privileges
- ☐ TV limits, read with child
- ☐ Questions about sex
- ☐ Family relationships
- ☐ Friends and playmates
- ☐ Pre-school, school readiness

Impression
- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ DTaP, IPV, MMR _____
- ☐ Vaccine Information Sheet
- ☐ Five year handout sheet
- ☐ See dentist
- ☐ RTC at _____ years
- ☐ _____
- ☐ _____
- ☐ _____

_____M.D. / P.N.P.

- ☐ See back for additional documentation

Provider ID# ☐☐☐☐☐☐☐☐☐☐☐☐

6	10	Y

EPSDT Screening Date

		/			/	2	0	0	

Member ID#

			–			–				

6 to 10 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update

Changes in your family history? No Yes

_____

Has the patient had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Parental Concerns

_____

_____

Nutrition

Low fat milk ?	yes	no
Variety of fruits/vegetables?	yes	no
Eats breakfast?	yes	no
[illegible] supper with family?	yes	no

[illegible]aring (test at age 10 or every 5 yrs if nl)
Hearing screen pass fail
Date _____

Vision (test every two years)
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____
☐ Wears glasses, sees eye specialist

School Grade _____
Problems? Yes No

_____

_____

TB Risk Factors* yes no
(see separate form)
PPD result _____

Lab Tests
Hgb _____
If abnormal or not done at age 5 years.

Cholesterol _____
If [illegible] factors and not done at age 5 yrs.
U[illegible]ysis (If abnl. or not done at 5 yrs.)
see back for results
*see separate form

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage	____
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage	____
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐

Safety
- ☐ Smoke detectors, no smoking in home
- ☐ Buckle up!
- ☐ Booster seat < 58", < 70#
- ☐ Bike helmet, street safety
- ☐ Water safety, swimming lessons
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition
- ☐ Low fat milk and snacks
- ☐ Encourage fruits and vegetables
- ☐ Brush teeth, see dentist
- ☐ Encourage sports, active play

Social/Behavioral
- ☐ School adjustment, performance
- ☐ Sports and hobbies
- ☐ Limit TV, computer games
- ☐ Give choices, encourage independence
- ☐ Set limits, provide consequences
- ☐ Privacy, personal hygiene
- ☐ Puberty changes and ? about sex
- ☐ Family relationships
- ☐ Friends and schoolmates
- ☐ Dealing with strangers
- ☐ Developmental/Behavioral Screen*

Impression
- ☐ Well Child, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.
☐ See back for additional documentation

Provider ID#

11	14	Y

EPSDT Screening Date ___/___/2000

Member ID# ___-___

11 to 14 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update

Changes in your family history?
No Yes

_____

Have you had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Concerns

_____

_____

Nutrition

Low fat milk ?	yes	no
Variety of fruits/vegetables?	yes	no
Eats breakfast?	yes	no
Eats supper with family?	yes	no

Hearing (age 14 and every 5 years if nl)

Hearing screen pass fail
date _____

Vision: (test every two years)

L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____

☐ Wears glasses, sees eye specialist

School

Grade _____
Problems? Yes No

_____

_____

TB Risk Factors yes no

(see separate form)
IPPD result _____

Lab Tests

Hgb _____
If abnormal or not done at age 5 years.

Cholesterol _____
Every 5 years if risk factors & previously normal.
Urinalysis (If abnl. or not done at 5 yrs.)
☐ see back for results

Physical Exam

undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage	___
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage	___
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐
Pelvic	☐

Safety

- ☐ Smoke detectors, no smoking in home
- ☐ Buckle up!
- ☐ Bike helmet, street safety
- ☐ Swimming, water safety
- ☐ Firearm safety
- ☐ Sunburn prevention

Health/Nutrition

- ☐ Low fat milk and snacks
- ☐ Healthy food choices
- ☐ Brush teeth, see dentist
- ☐ Acne
- ☐ Encourage sports, exercise
- ☐ Sports form attached yes no

Social/Behavioral

- ☐ School adjustment, performance
- ☐ Sports and hobbies
- ☐ Limit TV, computer games
- ☐ Give choices, encourage independence
- ☐ Set limits, provide consequences
- ☐ Saying no to tobacco, drugs, alcohol
- ☐ Puberty changes and ? about sex
- ☐ Periods (girls) LMP _____
- ☐ Friends, boy/girl friends
- ☐ Abstinence, birth control
- ☐ Developmental/Behavioral Screen (see separate form)

Impression

- ☐ Well Child/Adolescent, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals

- ☐ Immunizations current yes no
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID# _____

15	20	Y

EPSDT Screening Date | | | / | | / | 2 | 0 | 0 | |

Member ID# | | | | | | | | | | | |

15 to 20 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update
Changes in your family history?
No Yes

_____

Have you had any new problems or illnesses since the last visit? No Yes

_____

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Problems / Concerns

_____

_____

Nutrition

Low fat milk ?	yes	no
Variety of fruits/vegetables?	yes	no
breakfast?	yes	no
[illegible] supper with family?	yes	no

Hearing (age 14 and every 5 years if nl)
Hearing screen pass fail
date _____

Vision: (test every two years)
L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____
☐ Wears glasses, sees eye specialist

School Grade _____
Problems? Yes No

_____

_____

TB Risk Factors yes no
(see separate form)
IPPD result _____

Lab Tests
Hgb _____
At age 15 or if risk factors
Cholesterol _____
Every 5 years if risk factors & previously
r al.
U lysis (at age 15 or if risk factors)
☐ see back for results
☐ STD screening, PAP (see back)

Physical Exam undressed : yes no √ = nl X = abnl

General	☐
Head	☐
Neck	☐
Eyes	☐
Ears	☐
Nose	☐
Throat/Mouth/Teeth	☐
Chest	☐
Breasts/Tanner Stage ____	
Lungs	☐
Heart	☐
Abdomen	☐
Femoral Pulses	☐
Genitalia /Tanner Stage ____	
Female	☐
Male	☐
Extremities	☐
Spine	☐
Skin	☐
Neuro	☐
Pelvic	☐

Safety
- ☐ Smoke detectors
- ☐ Driving and automobile safety
- ☐ Bike safety, helmets
- ☐ Swimming, water safety
- ☐ Firearm safety
- ☐ Sunburn prevention, tanning beds

Health/Nutrition
- ☐ Healthy food choices, Ca++ intake
- ☐ Concerns about weight, body image
- ☐ Periods (girls) LMP _____
- ☐ Breast/Testicular Self Exam
- ☐ Acne
- ☐ Encourage sports, exercise
- ☐ Sports form attached yes no

Social/Behavioral
- ☐ School adjustment, performance
- ☐ Plans for work and further education
- ☐ Friends and fun
- ☐ Tobacco use
- ☐ Drug and alcohol use
- ☐ Boy or girl friends
- ☐ Abstinence, birth control
- ☐ STDs
- ☐ Family relationships
- ☐ Developmental/Behavioral Screen (see separate form)

Impression
- ☐ Well Adolescent, normal growth and development
- ☐ _____
- ☐ _____

Plan/Referrals
- ☐ Immunizations current yes no
- ☐ Meningococcal vaccine, Adult dT
- ☐ RTC at _____ years
- ☐ See dentist _____
- ☐ Handouts _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____ M.D. / P.N.P.

☐ See back for additional documentation

Provider ID#

Name_____

Lead Poisoning Risk Assessment Questions

These questions must be asked at all EPSDT (TNCare) physical exams from 6 t0 72 months and are recommended for all 12 month and 2 year exams.

	DATE									
1. Does your child live in or regularly visit a house built before 1950? (This could include a day care center, baby sitter's home or the home of a relative.)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2. Does your child live in or regularly visit a house built before 1978 with recent, ongoing or planned renovations or remodeling (within the past 6 months)?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Does your child have a playmate or sibling that has, or did have lead poisoning?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Tuberculosis Risk Assessment Questions

These questions must be asked at all EPSD&T (TNCare) physical exams beginning at one year of age. They should be asked at all new patient physicals > one year, and at the one and five year check-ups and every 3-5 years.

	DATE									
1. Is your child in close contact with a person with tuberculosis?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2. Is your child foreign born (esp. Asian, African, Latin American), a refugee or a migrant?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Does your child live in a community in which there is a high risk for tuberculosis?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4. Does your child have a medical condition that suppresses the immune system?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
5. Is your child on any medications or treatments that suppress the immune system?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
6. Does your child have HIV infection or is he or she considered at risk for HIV infection?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
7. Is your child exposed to any of the following: HIV infected persons homeless individuals residents of nursing homes institutionalized adolescents or adults users of illegal drugs imprisoned adolescents or adults migrant farm workers	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

These questions follow the guidelines of the American Academy of Pediatrics and meet the requirements of the Tennessee Bureau of Tenncare.

STATE OF TENNESSEE
Bureau of TennCare
MCO EPSDT Coordinators
as of October 2002

TLC	Ms. Francine Brown 1407 Union Avenue Suite 200 Memphis, TN 38104	Phone: 901-725-7100, Ext. 3411 Fax: 901-725-2846 E-mail: fbrown@mmcc-tlc.com
PHP	Ms. Peggy McCurry or Ms. Mary Cogar 1420 Centerpoint Blvd. Knoxville, TN 37932	Phone: 865-470-7589 865-670-7338 Fax: 865-470-7404 E-mail: Pamccurr@covhlth.com Mdcogar@covhlth.com
Universal	Ms. Peggy Payne 1600 East Hill Street Spring Hill, CA 90806	Phone: 562-981-7509 Fax: 714-539-6791 E-mail: ppayne@universalcare.com
JDH	Ann Bly 408 North Cedar Bluff Road #400 Knoxville, TN 37772	Phone: 865-769-1599 Fax: 865-690-1941 E-mail: blyanng@johndeere.com
BHP	Ms. Marie Hawranko 300 Oxford Drive Monroeville, PA 15146	Phone: 412-856-5117 Fax: 412-380-7372 E-mail: mhawra@trhp.com
OmniCare	Ms. Margaret Lynch 1991 Corporate Avenue 5th Floor Memphis, TN 38132-1702	Phone: 901-348-3324 Fax: 901-348-3399 E-mail: mlynch@ochptn.com
VHP	Ms. Sela Desoto 215 Centerview Drive Suite 300 Brentwood, TN 37027	Phone: 615-782-7810 Fax: 615-782-7822 E-mail: sdesoto@vhptn.com
BCBST	Ms. Donna Roddy 801 Pine Street – 2G Chattanooga, TN 37402	Phone: 423-752-6458 Fax: 423-763-3248 E-mail: Donna_roddy@bcbst.com
XHP	Ms. Julia Patton 3402 West End Avenue Suite 470 Nashville, TN 37203-1069	Phone: 615-463-1666, Ext. 2277 Fax: 615-279-1253 E-mail: jpatton@xhtmail.com

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DRAFT

TNAAP
Website Recommendation

The following is a draft table of contents of TNAAP's recommended EPSDT website. The contents will include an expanded version of the materials included in the educational materials, links to other key EPSDT websites and information about EPSDT training resources.

DRAFT

TNAAP
Early Periodic Screening Diagnosis and Treatment (EPSDT)
On-line Guide

Draft Table of Contents

- Laboratory
- Immunizations
- Hearing
- Vision
- CPT Modifiers

Documentation Forms/Questionnaires

- TNAAP EPSDT chart documentation forms
- Lead Screening forms
- TB Screening forms
- History?

TNAAP as a resource for training programs

- Training in your office
- Training in your community
- Independent learning materials (videos, CDs, etc.)

Legal

- References to legal descriptions of EPSDT
- Legal actions against the state

Health Departments

- Why the Tennessee has health departments performing EPSDT screens
- Health Department Contact information

Other EPSDT Resources

- Profession articles
- Other web sites with EPSDT information

Ask us an EPSDT questions (e-mail link)

Attachment III
Outline of Coding Educator Recruitment Activities

Outline of Coding Educator Recruitment Activities

Two different rounds of advertisements were placed in the classified section of the Knoxville News Sentinel and the Tennessean on the following dates:

- Knoxville News Sentinel: 07/21/02 and 10/13/02
- Tennesseean: 07/21/02 and 11/24/02 and 12/01/02

The job description was posted on the following web site:

- Tennessee Health Information Management Association (THIMA) Web site, August, 2002

Contact was made with the following organizations to get the word out to students and or staff:

- Colleges:
  - Volunteer State Community College, Gallatin, TN
  - Roane State Community College, Knoxville, TN

- Professional Organizations:
  - Cumberland Pediatric Foundation
  - Nashville Medical Society
  - Various local chapters of the American Association of Coders

A total of 14 resumes were received.

Approximately ten telephone interviews were conducted and five in-person interviews were conducted.

Jacque Clouse, RHIT, CCP, has been hired for this position and will begin work with TNAAP on February 3, 2003.

Attachment IV
Newsletter Articles

the Tennessee Pediatrician

THE OFFICIAL PUBLICATION OF THE TENNESSEE CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY

FALL 2002

RSV PROPHYLAXIS-
ADMINISTRATIVE ROADBLOCKS TO TREATMENT

Suzanne Berman, M.D., FAAP
Chair, TNAAP Palivizumab-RSV Taskforce
sberman@plateaupediatrics.com

Lower respiratory tract infection with respiratory syncytial virus causes significant morbidity and mortality amongst the children of Tennessee. Monoclonal antibody prophylaxis with palivizumab (Synagis) has been shown to improve clinically meaningful outcomes for children who are at risk. Both the 1998 American Academy of Pediatrics Policy Statement and the 2000 Redbook recommend that infants born between 32-5 weeks gestation be considered for palivizumab prophylaxis if they have other risk factors; unfortunately, while the Policy specifically identifies those risk factors, e.g. day care attendance, crowded living conditions, and passive smoke exposure, the Red Book merely references them in general, stating that, "given the large number of patients born between 32 and 35 weeks gestation and the cost of the drug, the use of palivizumab...should be reserved for infants with additional risk factors". New data expands the "at risk" population to include children with congenital heart disease and argues that the yearly period of prophylaxis be flexible, determined by local epidemiologic data.

Payers in Tennessee have had a variable response to claims made for prophylaxis with this drug. One appears to have made it a policy to deny claims for palivizumab if the child was born after 32 weeks gestation, regardless of

continued on page 3...

Recertification: What is Really Happening?

Dave Tayloe, Jr., MD, FAAP
Chair, AAP District IV
919-580-7209; dtayloe@aap.org

Beginning January 1, 2003, pediatricians wishing to recertify with the American Board of Pediatrics (ABP) will follow a new protocol, which the ABP has named the Program for Maintenance of Certification in Pediatrics (PMCP). The PMCP is a four-part format that will be completely phased in by 2010. The four parts require physicians to provide evidence of:

1. Professional Standing (state licensure);
2. Lifelong Learning and Self-assessment;
3. Cognitive Expertise (closed-book secure examination); and
4. Satisfactory Performance in Practice.

By 2010, the four-part recertification process will be the norm for all pediatricians. Parts 1 and 3 will be required of pediatricians needing to recertify in 2003. Those pediatricians will be sent notices and details of the PMCP in September 2002. Parts 2 and 4 will be developed and phased in over time. The American Academy of Pediatrics (AAP) sponsors educational activities through Pedialink, PREP the Continuum (Pediatric Review and Education Program), and eQIPP (Education in Quality Improvement for Pediatric Practice) Programs that will help pediatricians prepare for Part 3, and fulfill the requirements for Parts 2 and 4.

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INSIDE

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Next Issue: Winter 2003

NEWSLETTER EDITORS
Catherine M. Fenner
Joseph F. Lentz, M.D.

President's Report

John C. Ring, MD, FAAP
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(w) 901-572-3292; jring@utmem.edu

To paraphrase the Chinese, we are truly "blessed" by the "interesting times" in which we Tennesseans find ourselves living today! The AAP Annual Chapter Forum in September brought the leadership of our organization together once again to discuss the future direction of the Academy. While it would be an overstatement to say that consensus was reached on every issue, I was proud to be a member of a group that consistently, candidly, articulately, and collegially advocated what's best for children and their providers. The AAP National Conference and Exposition in October provided superb CME focused towards practicing pediatricians and gave members ample access to Academy policymakers regarding both patient care and non-patient care issues alike.

Closer to home, your Chapter partnered with the Children's Emergency Care Alliance (CECA) in presenting a very successful CME meeting in Knoxville, "Advancing the Frontiers of Pediatric Emergency Care". Our EPSDT Contract with the TennCare Bureau has benefited both members and the State through the development of documentation templates that facilitate care, confirm compliance with external regulation, and, hopefully, will improve provider reimbursement. Our Pediatric Practice Managers' Network continues to grow, providing expert education and support to these key ancillary personnel. The Chapter supported the submission of several CATCH grants this cycle; the wealth of ideas presented in these submissions was matched only by the dire needs they addressed. The recent state and federal elections also present us with important challenges and opportunities.

Our Governor-Elect, his administrative appointees, and the members of the General Assembly also live in "interesting times". We need to make certain that they understand there is no policy issue of greater importance today than improving the health of the children of Tennessee. As a leading voice for children and their physician-providers in this state, the Tennessee Chapter of the American Academy of Pediatrics / Tennessee Pediatric Society recognizes that a point of crisis has been reached. In a letter to Mr. Bredesen, we emphasized the following concerns:

1. Every child deserves health care sufficient to maximize their potential for growth and development. The American Academy of Pediatrics has defined the standard of care that children should receive in order to achieve that goal. It is illogical, short-sighted in the extreme, and perhaps immoral to offer any less. As citizens, physicians, and, in many instances, parents, we can identify no valid rationale to exclude any child from such coverage.
2. Rates of compensation for children's health care remain unrealistically low. In many instances, pediatricians lose money providing necessary services to children; this is particularly true when it comes to preventive care. Adequate coverage cannot continue to be an underfunded mandate in any part of the richest country in the world.
3. Multiple obstacles exist to participation in TennCare, for both our patients and their providers. These obstacles have lead, inevitably, to the development of primary and subspecialty care networks that are woefully inadequate to treat the children for whom they are responsible. These obstacles now threaten to disenfranchise our patients regardless of their

continued on page 5...

RSV...continued from page 1

risk factors; even documentation that the infant has chronic lung disease has not always lead to approval. Other insurers have often approved payment for the drug, especially if the individual case is made to the payer's representative by the prescribing physician. Variable responses exist even within the programs administered by a single payer. A sound scientific rationale for denials is often not forthcoming.

The Tennessee Chapter of the American Academy of Pediatrics/Tennessee Pediatric Society is committed to providing children with all of the health care services that they require. We also want to provide these services in a cost-effective manner and we integrate that consideration into every management decision that we make; that is especially true in Tennessee where resources for health care remain limited. As busy practitioners, we rely heavily upon technical recommendations from the AAP, which we regard as the single best source for health care information about children. Thus, we are concerned that some payers are compromising the care which our patients deserve, placing us in the untenable position of having to deny palivizumab prophylaxis or accept the financial burden ourselves for its provision when the family cannot pay. It is possible that we will begin to encounter similar difficulties with influenzae vaccination.

We need help from our members, as follows:

1. Share your experiences with us in detail, especially those instances in which you feel claims were wrongfully denied.
2. Write to the Medical Directors of your major payers, encouraging them to follow AAP Guidelines (and thanking them if they are already doing so).
3. Encourage the AAP Committee on Infectious Diseases to keep its membership aware of changing recommendations in a timely fashion, especially as they pertain to cost-efficacy data. Make them aware, too, of how apparent inconsistencies between recommendations in the Policy and the Red Book complicate reimbursement for palivizumab prophylaxis for children born between 32-5 weeks gestation.

If you are interested in helping with palivizumab advocacy or if you are having problems with particular insurers, please feel free to contact me.

AAP HIPAA Privacy Manual and Other HIPAA Resources

The AAP HIPAA Privacy Manual has been updated to incorporate the most recent changes in the Privacy Rule (published on August 14, 2002). Don't miss this tremendous resource! The manual provides step-by-step instructions for evaluating your practice and implementing necessary requirements associated with privacy. The manual includes sample checklists, forms, vendor contract templates and more.

To download the HIPAA Privacy Manual go to www.aap.org/moc and log-in using your AAP Member ID # and password (typically your last name up to 12 characters). Click on HIPAA (left side of screen) and select Updated HIPAA Privacy Manual.

The Office of Civil Rights (OCR) released "Guidance Explaining Specific Aspects of the Privacy Rule" on December 4, 2002. OCR is the government agency charged with enforcing the privacy regulation and this document provides background information and further clarification regarding their expectations. You can review this document at: www.hhs.gov/ocr/hipaa/privacy.html.

Also, check out the TNAAP website (www.tnaap.org) for links to other useful websites for HIPAA information. Remember that you must be in compliance with the privacy requirements by April 14, 2003.

HIPAA Updates

Have you been receiving our HIPAA updates via e-mail? During the last few months, you should have received email communications regarding:

- Filing an extension for "Transactions and Code Sets" (the deadline was October 15, 2002)
- Information about the revised final "Privacy Rule", and
- Notices about HIPAA round table conference calls with the Center for Medicare and Medicaid Services (CMS)

If you did not receive these communications, chances are we do not have your email. Please forward your e-mail address to the Chapter office at tnaap@aol.com.

Getting a new computer this holiday season?

We would like your old one! If your "old" computer is less than 4 years old, and you want to help our new Foundation (more on that in the winter newsletter) while getting a tax deduction in 2003, please contact our Program Director, Patrice, at 615-599-6359 or patricetnaap@comcast.net.

EPSDT Forms Endorsed by TNAAP

TNAAP and Blue Cross Blue Shield of Tennessee have partnered to develop Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation forms. These forms were created with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division.

Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

The most recent forms more accurately reflect the specific requirements within each age group and more closely follows the "work flow" of the physical. Many offices have found using different colors of paper for each age group to be very helpful.

Electronic copies of these forms can be found on our web site at www.tnaap.org. We hope you will find these useful. We will continually be striving to improve the forms so if you have suggested changes, additions or questions, please contact our EPSDT Director, Ruth Allen, at ruthеallen@yahoo.com or at 865-927-3030.

Visit our web site
www.tnaap.org

Welcome New Members

George A. Adams, Jr, DDS	Nashville
Frank H. Alden, DDS	Johnson City
John T. Algren, MD	Nashville
Youhanna S. Al-Tawil, MD	Knoxville
Judith Deane Anderson, MD	Nashville
Ellen Andrews, MD	Knoxville
Sandra Ruth Arnold, MD	Memphis
John T. Beuerlein, MD	Knoxville
Bradley P. Carter, MD	Memphis
Farah L. Cassis, MD	Nashville
Ricardo Causo, MD	Chattanooga
Jason Troy Cheney, MD	Oak Ridge
Caroline H. Chester, MD	Nashville
Roger Allen Coffman, MD	Chattanooga
Merri Shaw Collins, MD	Franklin
Cathy A. Dailey, DO	Clarksville
Michelle Lee Davenport, MD	Johnson City
Andrew Davidoff, MD	Memphis
Elizabeth Ponder Dykstra, MD	Nashville
Jennifer Stone Erdin, MD	Memphis
Emad Abdel Fattah, MD	Union City
Deborah Maria Fernandes, MD	Dyersburg
Roy Anthony Friddell, MD	Chattanooga
R. James Garrison, MD	Murfreesboro
George Walden Garriss, III, MD, MS	Brentwood
Javel M. Granados, MD	Collierville
Sheldon M. Graves, DDS	Memphis
Veronica L. Gunn, MD	Nashville
Scott Osborn Guthrie, MD	Hendersonville
Mark Edward Halstead, MD	Nashville
Rodney Mack Hamilton, MD	Brentwood
Julie K. Hudson, MD	Nashville
David Gordon Johnston, MD	Memphis
Jeanie Jung, MD	Chattanooga
Stuart J. Kaplan, MD	Memphis
John Austin Kirby, MD	Jefferson City
Tammy Lin Kitchens, MD	Johnson City
Kelly Lynn Kriwanek, MD	Memphis
Melissa Lorraine Lambert, MD	Nashville
Aubrey Lamptey, MD	Hartsville
Tiffany P. Landon, MD	Columbia
Christopher R. Ledes, MD	Johnson City
Suzanne Marie Lopez, MD	Memphis
Jeff Mann, DO	Paris
Allison S. McBride, MD	Nashville
Joshua M. McCollum, MD	Murfreesboro
Steven J. McElroy, MD	Nashville
Mary Kathryn McNeal, MD	Dickson
Martha Miller, MD	Memphis
Tracie Lynn Overbeck, MD	Memphis
Keith Bennett Owen, MD	Memphis
Lea Kristin Parsley, MD	Chattanooga
Sara Fletcher Patterson, MD	Nashville
Aurelia Radulesca, MD	Morristown
Vlad Radulesca, MD	Tazewell
Alice M. Rothman, MD	Nashville
Dawn Heather Scott, MD	Memphis
Josh Shook, MD	Knoxville
Maria Stephan, MD	Knoxville
Stephanie Howard Stovall, MD	Memphis
J. Tyson Sullivan, MD	Lebanon
Barbara Summers, MD	Knoxville
Jeffrey David Thompson, MD	Memphis
Mary Olivia Titus, MD	Nashville
Penny J. Walsh, MD	Memphis
Travis Thomas Walters, MD	Nashville
Sally Ammon Watson, MD	Nashville
Gene L. Whitington, MD	Memphis
Mark Alan Williams, MD	Memphis
Stacey Marie Williams, MD	Nashville
Clifton W. Woolley, MD	Memphis
Thomas Zerfoss, MD	Nashville

Recertification...continued from page 1

If you are a pediatrician needing to recertify in 2003, you may access the ABP website at www.abp.org, or contact the ABP at pmcp@abpeds.org. You will need to successfully complete parts 1 and 3 during calendar year 2003, to avoid a lapse in certification. The ABP has posted its Knowledge Self-assessment on its website to help pediatricians prepare for the types of questions and computer testing format that will be used for the closed-book proctored exam. You can register for the PMCP through the ABP website starting in January 2003. The registration process will consist of documenting that your state licensure is current and paying, via credit card, the $1120 recertification fee. You will also be able to schedule your examination place, date and time using a toll-free telephone number, or you may use the Prometric web site (www.prometric.com) to reserve a place, date, and time much as you would when purchasing an airplane ticket on the Internet.

The examination will be given in Prometric Testing Centers (formerly Sylvan Learning Centers) and Prometric will take responsibility for making sure the examination is "secure." There are over 400 such centers in the US and Canada. The generalist's exam will be offered nine months out of the year (April through December). The closed-book secure examination will consist of approximately 200 multiple choice questions and applicants will have 4.5 hours to complete the test (including a tutorial). If an individual fails the exam, he/she will be able to retake the examination for $195.00. There is no limit to the number of times an individual may take the examination.

Subspecialists who also wish to maintain certification in general pediatrics will need to take the generalist's examination. If subspecialists choose to remain certified only in their subspecialty, they will only be required to take the examination for their subspecialty. Those holding more than one ABP certificate, who wish to take more than one recertifying examination, may pay for an additional recertification examination at two-thirds the relevant fee. Many of the Parts 2 and 4 activities will overlap for specialists wishing to maintain generalist certification, thus reducing the burden of maintaining multiple certificates.

Most pediatricians admit the new format is more comprehensive and more likely to engender the trust of the public; however, they feel uneasy about the closed-book secure examination format for Part 3. Pediatricians complain that the closed-book situation does not measure the busy pediatrician's ability to answer questions by contacting colleagues, accessing reference publications, or going on-line. The AAP has expressed its concerns about Part 3 to the ABP. The ABP, however, feels strongly that it maintain this format for a number of reasons: it has evidence that other medical specialties are developing this type of recertifying examination; the American Board of Medical Specialties, which is the umbrella organization for 24 national medical specialty boards, is considering a resolution that all recertification examinations must be administered in a secure format; and, some state licensing agencies are likely to require a secure examination as part of a maintenance of state licensure if recertification is used to fulfill a requirement of license renewal. Prometric Testing Centers do not permit an open-book format for the examination because they administer multiple different examinations on the same day and no other organizations (eg, National Board of Medical Examiners) allow the open-book format.

The AAP, while not responsible for certifying or recertifying pediatricians, does have a strong commitment to meeting the educational needs of the practitioner (including education for preparation for renewal of certification). Therefore, the AAP will continue to work closely with the ABP to ensure AAP professional education activities assist pediatricians in meeting all of the maintenance of certification requirements. The AAP has never excluded a Fellow from the organization because the Fellow failed to recertify. Please feel free to communicate your concerns about recertification to me as I represent you on the Board of Directors of the AAP.

I wish to thank Hazen Ham, Ph.D., Director of Recertification Programs for the American Board of Pediatrics, and Errol Alden, M.D., F.A.A.P., Deputy Executive Director of the American Academy of Pediatrics, for helping me write this commentary.

President's Message...continued from page 1

eligibility. Children with special needs are particularly vulnerable. Children's healthcare coverage cannot become a cynical, empty promise to our posterity.

We recognize that the challenges faced by State government are formidable and that time, energy, and resources are finite. We appreciate the attention that was given by all of the candidates to our issues this year; however, the election is now over and the line of responsibility is clear. We will bring to the effort not only a compelling definition of the problems, but concrete, workable solutions, based on the experience and convictions of our group. Working together, as people of good will, vision, and energy, we can reach our common goal: quality healthcare for the children of Tennessee regardless of means.

Children in State Custody

The Tennessee Department of Children's Services (DCS) has requested assistance from TNAAP regarding issues related to EPSDT services for children in state custody. DCS acknowledges the difficulty that physicians have in obtaining historical information on children in state custody and the problems performing an EPSDT screen without this information. They are trying to improve their processes and want specific feedback about physician issues. They are asking pediatricians to contact the DCS Health Unit Nurses (listed below) as difficulties arise so they can better address problems in their respective areas. They also request that, in those cases where little or no information can be obtained, we go ahead and see the child and complete as much of the screen as is feasible.

Dept. of Children's Services
HEALTH CARE ADVOCACY STAFF LIST (as of October 3, 2002)

REGION	NURSE	PHONE
Davidson	Patricia Slade, RN, MSN, MBA	615-253-5127
East Tennessee	Scott Melton, BS, RN, CCM	865-425-4527
Hamilton	Chip Dantzler, RN	423-634-3493
Knox	Katressa Tipton, MSN, RN, CPNP	865-594-7101 - Ext. 18
Mid-Cumberland	Patsy Sanford, RN	615-333-5425
Northeast	Rebecca Reed, RN, BSN, ANP,CS	423-727-1052
Northwest	Phyllis Parker, RN	731-884-2633
Shelby	Gerald Brown, RN	901-578-4078
South Central	Lynn Pollard, MSN, RN, CPNP	931-375-2000
Southeast	Cheryl Brazelton, RN, BSN	423-493-5960
Southwest	Sara Webb, RN	731-426-0782
Upper Cumberland	Tanna Short, MSN, RN-C, FNP	931-646-3027
Central Office	David DeGrella Program Coordinator 615-532-2267 Fax -615-741-7322 Primary Areas: MCO, TennCare Eligibility, and data quality	Diana Yelton Program Coordinator 615-253-4703 Fax -615-741-7322 Primary Areas: BHO, DCS appeals, and custody prevention for noncustody children.

Fenner, Lentz, and Ring receive the AAP Outstanding Large Chapter Award, presented by Wyeth-Lederle reps Susan Lincoln and Mike Dugan, on either side of Lentz. The beautiful plaque was accompanied by a $2000 check also from Wyeth.

2003 Calendar

Jan 18, 2003	TNAAP Board Meeting* Nashville
Apr 11, 2003	TNAAP Board Meeting* Montg. Bell State Park
Apr 12-13, 2003	TNAAP Planning Retreat Montg. Bell State Park

** All Chapter members are invited to attend the Board meetings, but please let the Chapter office know at least 2 weeks in advance.*

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2002 National Early Hearing Detection and Intervention Meeting

Mark S. Gaylord, MD
865-544-9320; mgaylord@mc.utmck.edu

I was honored to represent the Tennessee AAP Chapter at the Early Hearing Detection and Intervention (EHDI) Meeting in Washington D.C. earlier this year. This valuable meeting was co-sponsored by the CDC, HRSA, All Kids Count, National Center for Hearing Assessment and Management, National Institute on Deafness and Other Communication Disorders, Department of Education, and the AAP. The purpose of the meeting was to continue the goal of providing universal hearing screening to all infants. The AAP has become a major partner in this endeavor and sponsored a contact person from each state to attend. I will continue to serve as the Chapter's EHDI representative.

Congenital hearing loss affects 2-3/1000 infants in Tennessee and the United States. Hearing loss occurs more frequently than other screened newborn conditions (0.1/1000 births have PKU; 0.25/1000 births have hypothyroidism, 0.20/1000 births have sickle cell, 2.3/1000 have hearing loss). Infants with undetected or untreated hearing loss will not develop language and communication skills at age appropriate levels. The average age of identification of a deaf child is 14-22 months. Since any degree of hearing loss can affect language and school performance and birth to age 3 years is the most critical learning age for language development, it is not unexpected that one third of children with hearing loss in just one ear had to repeat a grade in school, and the average twelfth grade deaf child reads at a third to fourth grade level.

Technology is now available to reliably screen infants at birth (otoacoustic evoked emissions automated auditory brainstem responses). There is no "best" protocol, but several have been proven to work. Each screening center chooses the one that fits their situation best. Since 1994, there has been a large increase in infants screened (2001 > 2000 hospitals) with 67% of infants screened nationwide. Referral rates nationally are 2.2% (CDC data). We now screen about 75% statewide in Tennessee with reported referral rate of 0.9 to 2%. With these large numbers of infants screened, it truly has become "standard of care". The average cost for hospital-based screening is $26/infant; however, the cost of educating a hearing impaired child is $9,689 in regular classes to $35,780 in residential programs.

Studies have now shown that infants in treatment will develop near normal. Therefore, the goals of EDHI programs are to screen infants by 1 month, have a complete diagnosis by 3 months and intervention by 6 months. It is the AAP's desire that this process be integrated and linked with the pediatric medical home.

With grants from HRSA and CDC and the incorporation of newborn hearing screening in the 2003 EPDST Tennessee regulations, Tennessee hopes to exceed 90% screened. Plans are also in progress to link the reporting of referred newborn screens with the state metabolic screen form. The Department of Education, IDEA Part C Programs that include the Tennessee Early Intervention System (TEIS) and Tennessee Infant Parent Services (TIPS), will help with coordination of services for the referred infants. TEIS service coordinators work in each county in the state. The program has over 13 years of experience in working with children birth to 3 years old that may have hearing loss or developmental disabilities. TIPS school parent advisors also work in each county of the state. This program has over 35 years experience working with families who have young children with hearing loss. These groups can assist with referrals to appropriate pediatric audiologists for definitive diagnosis and amplification and referral to early intervention specialists for other treatment, if necessary.

A large amount of research and work has occurred in the past 5 years for the diagnosis of congenital hearing loss. Outcome data now supports that early diagnosis and treatment can help avoid long-term social behavioral and educational developmental delays. In a short 7 years, the U.S. has gone from 19% of infants screened to 67%. We also have made great progress in Tennessee, but we still have at least 25% of children not being screened. The AAP is asking all pediatricians to "champion" the goal of screening all children by one month of age and include diagnosed children in their medical home. We truly have a lot of work left to do.

Please help us screen all children in your community. Also feel free to contact me about this important issue.

References: 1) American Academy of Pediatrics Task Force on Newborn and Infant Hearing, Newborn and Infant Hearing Loss: Detection and Intervention. Pediatrics. 1999b; 103:577-530. 2) American Academy of Pediatrics, Ad Hoc task Force on Definition of the Medical Home. The Medical Home. Pediatrics. 1998, 90:774. 3) Joint Committee on Infant Hearing Position Statement: Principles and guidelines for early hearing detection and intervention programs. Pediatrics. 2000; 106:798-817. 4) Moeller MP. Early intervention and language development in children who are deaf and hard of hearing. Pediatrics. 2000; 106:e43. 5) Yoshinago-Itano C., Sedey A.C., Coulter RA, Mehl AL. Languages of early and later-identified children with hearing loss. Pediatrics. 1990; 102:1168-1171. 6) Yoshinago-Itano C. Universal newborn hearing screening assessment and intervention systems. Hearing Journal. 1999; 5216: 10,12,14,16,19, 20-21.

Great Web Sites

1. www.babyhearing.org
   Boys Town National Research Hospital
2. www.infanthearing.org
   National Center for Hearing Assessment

Tennessee Resources

1. Jacque Cundall, Tennessee Department of Health
   615-741-310 jcundall@mail.state.tn.us
2. TEIS 1-800-852-7157

TennCare Benefits

AMN = As medically necessary

Benefit	TennCare Coverage through 12/31/02	TennCare Medicaid Coverage 1/1/03	TennCare Standard Coverage 1/1/03
Inpatient hospital services	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN, with rehabilitation hospital services covered only as a cost-effective alternative
Outpatient hospital services	AMN	AMN	AMN
Physician inpatient services	AMN	AMN	AMN
Physician out-patient services	AMN	AMN	AMN
Physical exams and check-ups	Covered	Covered for children through EPSDT; covered for adults according to TennCare schedule	Covered according to TennCare schedule (AAP guidelines for children)
Lab/X-ray services	AMN	AMN	AMN
Hospice care	AMN	AMN	AMN
Dental services	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth [Additional dental package of services for children will be available for family purchase]
Vision services	Preventive, diagnostic and treatment services for enrollees under age 21; first pair of cataract glasses or contact lens/lenses following cataract surgery for adults	Preventive, diagnostic and treatment services for enrollees under age 21; routine eye care not covered for adults	Annual eye exam covered for enrollees under age 21; other routine eye care not covered for children or adults
Home health services	AMN	AMN, with a limit of 125 visits per enrollee per year for enrollees age 21 and older	AMN, with a limit of 125 visits per enrollee per year
Pharmacy	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)
Durable medical equipment	AMN	AMN	AMN
Medical supplies	AMN	AMN	AMN
Emergency ambulance transportation	AMN	AMN	AMN
Non-emergency transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation
Renal dialysis services	AMN	AMN	AMN

TennCare Benefits...continued

AMN = As medically necessary

Benefit	TennCare Coverage through 12/31/02	TennCare Medicaid Coverage 1/1/03	TennCare Standard Coverage 1/1/03
EPSDT services	Screening, diagnostic and follow-up treatment services AMN	Screening, diagnostic and follow-up treatment services AMN	Not covered
Chiropractic services	AMN for children through EPSDT; covered for adults as a cost-effective alternative	AMN for children through EPSDT, covered for adults as a cost-effective alternative	Not covered
Private duty nursing	AMN	AMN for children through EPSDT; not covered for adults	Not covered
Speech therapy	AMN for children through EPSDT; covered AMN for adults when provided by a licensed speech therapist to restore speech after a loss or impairment	AMN for children through EPSDT, for adults, limited to 60 days period from the date therapy begins for any one condition	Covered as short-term benefit per condition; limited to 60 days from original treatment
Occupational therapy		AMN for children through EPSDT; for adults, limited to 60 days period from the date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Physical therapy		AMN for children through EPSDT; for adults, limited to 60 days period from date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Organ transplant and donor organ procurement	AMN; for adults, transplant must be non-experimental	AMN for children through EPSDT; for adults, limited to coverage of transplants also covered by Medicare	Limited to coverage of transplants also covered by Medicare for beneficiaries who have been enrolled in TennCare for a period of 6 months
Sitter services	AMN	Not covered	Not covered
Convalescent care	AMN	Not covered	Not covered
Reconstructive breast surgery	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	Covered in accordance with Tennessee Public Chapter 452
Psychiatric inpatient facility services	AMN	AMN	AMN
Physician psychiatric inpatient services	AMN	AMN	AMN
Outpatient mental health services	AMN	AMN	AMN
Inpatient and outpatient substance abuse treatment services	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and $30,000 in lifetime benefits	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and $30,000 in lifetime benefits	AMN limited to 10 days detox and $30,000 in lifetime benefits
Mental health case management		AMN	AMN
24-hour residential treatment	AMN	AMN	AMN
Mental health crisis services	AMN	AMN	AMN

Cola Wars

Tennessee Society of Pediatric Dentistry
(Compiled by Ed Perdue, DDS, Hendersonville
615-824-1700)

Americans consume soft drinks at an alarming rate. During the time period from 1978 to 1994, soft drink consumption by U.S. teens tripled. By 1998, Americans were consuming 15 billion gallons of soft drinks, equivalent to 558 12oz cans per person per year. The National Soft Drink Association reports that one out of every four beverages consumed in America is a soft drink. This averages to 56 gallons per year for every person in the United States. Consumption among males 12-19 years of age can be as high as 81 gallons per year.

The consumption of highly sugared, acidic, caffeinated, carbonated beverages contributes to the rapid onset and progression of dental caries in children and adolescents. The habit forming potential of the caffeine in these beverages only increases the concerns about dental disease and the overall health of children and adolescents.

According to the Center for Sciences in the Public Interest, twenty percent of one and two year old U.S. children drink soft drinks, with an average consumption of seven ounces per day, containing over 50mg of caffeine. There is concern that the pattern for caffeine ingestion begins at a very early age, as its use in medications, soft drinks, and other foods for children is common and accepted. Regular caffeine ingestion may lead to habitual usage.

The increase in cola consumption combined with an apparent decrease in the consumption of milk not only increases the risk of dental caries in children and teens, but may contribute to a wide range of other health problems, including a decrease in bone density and a subsequent increase in fractures.

National marketing and advertising campaigns for many products, especially colas, have aggressively targeted the child and teen markets. The American Dental Association has expressed concern about "pouring rights contracts" which give soft drink companies exclusive rights to place vending machines in schools in exchange for large monetary contributions.

Caffeinated carbonated beverage consumption poses significant risk to the overall heath to children in America. Education is the key to helping families make informed choices about the products they purchase and consume.

Annual Board Planning Retreat May 2002 Fall Creek Falls State Park

Above: Immediate Past President Joe Lentz, MD, with wife Betty.

Below: (r-l) Mick Connors, MD, Bob Lembersky, MD, Ovidio Bermudez, MD, and Pat Strauss with members of the Lembersky family.

AAP President Steve Edwards, MD, enjoys the beauty of Tennessee.

Volunteer leaders work to set the course of TNAAP's future.

Local Pediatric Society Updates

Davidson County Pediatric Association (DCPA)

Beverly Frank, MD, President
bevfrank@comcast.net
615-851-7865

Davidson County's Overall Dinner

DCPA had two meetings earlier this year. In late March, we met with Dr. Pedro Garcia, Nashville Metro's school superintendent. He presented his plans for increasing reading and math scores in the school system as well as his philosophy of educating children. He encouraged us to emphasize to all our parents how important it is to read with their children on a daily basis. This could be done at every physical exam, starting with infants. He also feels that this practice should continue through middle school, always reading to your children at a level higher than theirs so they are pushed to learn new vocabulary and discuss ideas with you. In May, DCPA and Vanderbilt co-hosted the annual dinner that is in memory of Dr. Overall. The speaker this year, Dr. George Lister from Yale University, discussed what he has learned over the years from his mistakes.

Hamilton County Pediatric Society

Tomasz Voychehovski, MD, President
423-855-0841
tomekvoy@cs.com

Hamilton County's Picnozium

The Hamilton County Pediatric Society (which includes Chattanooga and the surrounding area of southeast Tennessee) had its first Pediatric Picnic (tagged by some as the "Picnozium") at the scenic Harrison Bay State Park in April. The Society was generously supported by the companies of Daiichi, McNeil, Lederle, Ross, and Sepracor. With the fantastic spring weather, pediatricians and their families enjoyed camaraderie, food, tennis, hiking, and stories by actress/storyteller Colleen Laliberte. The Society committed its new projects to the following:

(1) promoting breastfeeding and prenatal visits in alliance with ob-gyn and family practice doctors, and

(2) the cooperation between librarians and pediatricians to promote reading.

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TENNESSEE PEDIATRIC SOCIETY

SPRING 2002

CMS, VACCINES and the PEDIATRICIAN

Joel F. Bradley, MD, FAAP,
CPT Coding Advisor
(w) 615-936-6053

Immunizations are part of what we do, and changes in the Medicare fee schedule for 2002 threaten to change our ability to keep our kids protected against disease. Developing a strategy to deal with this in your practice requires the information summarized below.

The problem- As you may recall about three years ago, billing for vaccines changed at the request of the CDC to create separate CPT codes for vaccine products and their administration. New codes for vaccine administration were developed, and in their present form allow one to bill for the first vaccine administered (90471) and subsequent vaccines (90472 for each). For a typical two month old, if one gives 4 vaccines, we submit a CPT code for each vaccine product, 90471 (once) and 90472 (three times). With over twenty vaccines given during childhood and more to come, a little change in the reimbursement fee can produce a great change in the practice's bottom line at year's end.

CMS (formerly HCFA, now the Centers for Medicare and Medicaid Services) has published for the first time this year the relative values for 90471-2- but *without* the physician work value that was well demonstrated by our AAP surveys and recommended by the AMA RUC (relative value update committee) to CMS. As you can see from the table below, this omission lowered the total relative value by about 60%, and considering the CMS-imposed 5% decrease in the 2002 conversion factor, the reimbursement totaled $3.98. CMS equates the code to the antibiotic administration code 99078.

continued on page 4...

District IV Chair Commentary:

Coparent or Second-Parent Adoption by Same-Sex Parents

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dtayloe@aap.org

Board members of the AAP have been besieged by angry AAP Fellows and lay citizens since the publication of the Policy Statement and Technical Report on the topic of Coparent or Second-Parent Adoption by Same-Sex Parents in the February issue of Pediatrics. The Committee on Psychosocial Aspects of Child and Family Health (COPACFH) wrote these documents, multiple groups within the AAP reviewed them, and all ten members of the Board of Directors approved them. The process of developing the Intent for Statement/Technical Report and completing the work leading to publication in Pediatrics took about three years.

I came on the Board in late October of 2001, and these documents were approved before my official duties on the Board began. When I learned of the documents after the first critical media blast, I read and studied both documents and became involved in Board-level discussions, as well as discussions with AAP Fellows and lay citizens. I believe the Committee attempted to carve out a very unusual situation and address the needs of the at-risk child who finds himself/herself

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INSIDE

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Next Issue: Summer 2002
Deadline for entries: May 10, 2002

NEWSLETTER EDITORS
Catherine M. Fenner
Joseph F. Lentz, M.D.

President's Report

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I am back at my childhood home, and it is real winter here. My wife Adriana and I are driving up the North Shore of Lake Superior to Bearskin Lodge, an old bass fishing camp in the Arrowhead Country of Northeastern Minnesota, where the wilderness blurs off into Canada. The rental car is warm, and I've managed to retain some skills for driving on ice and snow. Public radio's pledge week programming is dominated by the fight that state legislators are making to return their income tax rebates to Governor Ventura and apply them, instead, to support of the public schools. Amazed, we turn the radio off and listen to zydeco music on the disc player. For the fifteenth year in a row, we are joining the same group of friends for a long weekend of cross-country skiing, fellowship, and good food. Bearskin is beautiful, pristine and remote; contact with the world is limited to French-language hockey games on the radio and to a single, communal telephone. It is a place that lends itself to reflection, as does this time of life for me.

Curiously, my thoughts turn to the Chapter and not just because this report is due upon my return. Direct patient care remains a rewarding, sometimes still an exhilarating, experience for me, but I increasingly feel the need to reach beyond these very personal encounters in hope of impacting children's lives more broadly. Unabashedly, I have come to recognize that what is good for pediatricians is good for children, too. The Chapter provides the ideal venue for this type of action, one in which we can work together to improve children's healthcare at both the State and the National level. The Tennessee Chapter has an important perspective to share with the National organization. Consider our practical experience with universal health insurance coverage for children; as pediatricians, we share a common goal with our colleagues in other parts of the country but, as we have learned to our dismay, "the devil is in the details". Similarly, we recognize the importance of clearly identifying and thoroughly discussing our social agenda as we make policy. Closer to home, it is my hope and intention that new Chapter initiatives, e.g. the EPSDT contract already in place and the developing task forces on HIPAA regulations and Synergis reimbursement, will provide real value to our members. Your Chapter leadership is working to re-invigorate our committee system, modifying its structure to more completely engage the talents of our members and bring them to bear efficiently on issues of substance.

Nothing will come to us for free. Our busy professional and personal lives necessitate that we apply a healthy skepticism to any demands made upon our time and energy. It will require the courage of our convictions to advocate for tax reform, recognizing that, regardless of the cost, we must take control of the process in support of education and healthcare. I am confidant that we will make the effort and that our effort will be successful. I am truly grateful for the opportunity to work with you over the next two years. It is good to be at home in Tennessee.

Legislative Advocacy

Catherine M. Fenner, Executive Director

Executive Director's Report
Catherine M. Fenner

Just prior to the reconvening of the 102nd Tennessee General Assembly, Vanderbilt's pediatric residency program held an Advocacy Week in January. Organized by Chief Resident Dr. Jason Kastner (some of you may remember Jason as one of my legislative interns last year), we spent three lunch hours during the course of a week discussing various types of advocacy. The first day I presented the basics of legislative advocacy. The second day, our Chair of the Committee on Children with Special Needs, Dr. Quentin Humberd from Clarksville, spoke about community advocacy and specifically the Medical Home project he has been working on with Family Voices. Our Program Director, Patrice Mayo-Ligon, also used our recent bicycle helmet campaign as an example of a Chapter member (Dr. Mick Connors) making his interest in injury prevention and a bright idea come to fruition. We wrapped up the week with a concrete example of legislative advocacy by having Representative Gene Caldwell, Representative Kim McMillan, and Dr. Ellen Wright Clayton discuss last year's passage of the bill that granted absolute immunity to pediatricians when reporting suspected child abuse. Dr. Clayton was instrumental in the passage of that bill by spending countless hours on the Hill explaining to the legislators the real-life situation faced by pediatricians. Rep. McMillan, who sponsored the bill in the House, received the 2001 Legislator of the Year Award for her efforts.

During the first active month of session (February), I was blessed again to have two wonderful third-year pediatric residents commit their month of advocacy to learning the ropes on the Hill; this brings the number of residents trained through this arrangement with Vanderbilt to eight. Dr. Alison Asaro and Dr. Buddy Creech were constantly researching and reading bills, identifying bills of interest and sitting through hours of committee discussions. As often happens, their medical expertise was particularly helpful when we were approached by many sides regarding a bill to allow glucagon administration in schools and another mandating schools to report the number of children taking medications in schools for ADHD. (See article on back page.)

Meanwhile, we have quietly held at bay the annual bill to grant prescribing authority of psychotropic drugs to pyschologists, the other annual nightmare to lift the ban of firearms on playgrounds and school property, and a bill which would require all children entering any pre-K or Head Start program to have a vision screening performed exclusively by an optometrist or ophthalmologist. As the Committees are working to close down so they can turn their attention to the budget crisis, these bills should be gone-- for this year, anyway. We continue to forge new alliances with other lobbying groups on the Hill, which has been extremely helpful in defeating these bills.

Dr. Quentin Humberd discusses community advocacy and his Medical Home project with Vanderbilt pediatric residents during January's Advocacy Week.

In addition to the optometrists' and psychologists' bills mentioned above, scope of practice bills are abundant this year. The Tennessee Medical Association (TMA) continues to address legislation that expands the scope of practices of "advanced practice nurses", chiropractors, orthopaedic PAs, and podiatrists.

Of course, the budget remains an enigma for most legislators, and they do not seem to understand that already the needs of children in this state are not being met, and to make more cuts will only do more harm. I encourage each of you to voice your personal opinions on tax reform to your own state senator and state representative. And please, get involved in an election this year, whether it be the gubernatorial race, the U.S. Senate race, the 4th, 5th, or 7th Congressional races, or your state senator or state rep race. Your time, as well as your dollars, do not go unnoticed and can make a lasting impression.

Rep. Kim McMillan (center), along with Dr. Ellen Clayton and Rep. Gene Caldwell, explain the importance of legislative advocacy during Vanderbilt's Advocacy Week in January.

...CMS, Vaccines, continued from page 1

Code	Proposed work rvu run by AAP-AMA	Total published work rvu - CMS	Total reimbursement AAP-AMA	Total reimbursement CMS 2002
90471	0.17	0	$10.14	$3.98
90472	0.15	0	$9.41	$3.98

CMS maintains that physicians do not spend time counseling patients about the vaccines (informed consent). While this may be true to some extent for the adult influenza and pneumonia vaccine (often given outside the practice setting such as a drugstore), it is not reflective of our practice as pediatricians. In fact, the work is increasing as many well-publicized (Rotavirus vaccine, intestinal obstruction) and unsubstantiated adverse affects (MMR-autism) appear. To make matters worse, CMS did not consider the well-demonstrated additional nurse time in giving vaccines versus another type of injection (documentation) and cost of materials like the Vaccine Information Sheets (VIS) we must furnish to each patient in an appropriate language.

Practice Impact- Since the values were never published until this year, all insurance companies and state Medicaid programs had to arrive at a reimbursement value without using the fee schedule. Surveys show values ranging from three to eighteen dollars, with an average of about $10 nationwide. If a pediatrician has 100 newborns a year, then on average the loss would be about $12,000 per year if those payers adopted the Medicare numbers (about two thirds of private payers or state Medicaid plans use the RBRVS).

The Solution- At the practice level, make sure you do not contract for the 2002 RBRVS fee schedule! Why not? First, it contains the low relative values for vaccine administration, and secondly the lower conversion factor for 2002 drops the payment for all codes by over 5%. Stay with the 2001 schedule and the 2001 conversion factor. Next, start checking your remittances from payers and see where they are headed. A call to the plan's medical director may help educate them and create a quality concern for the plan. The changes to the fee schedule codes and the conversion factor may apply to the state of affairs in the Medicare world, but neither change should apply to service to children or any non-Medicare patient and service.

At the state level, report to TNAAP any payers who are using the new values so the Chapter can both monitor the size of the problem and lobby on your behalf to repeal the changes. State Medicaid officials have been apprised of the potential impact this would have on both immunization rates as well as EPSDT screening rates if physicians were unable to afford giving vaccines in the office.

On a national level, write or call your U.S. Senators and Representatives-- there is even a form letter preprinted on the AAP website that can be modified for your practice and your concerns. Meanwhile, the AAP continues to work with CMS for a remedy.

(For another discussion of the subject, see February AAP NEWS, Washington Report. If you need a basic refresher on the Medicare Fee Schedule, look for the new 2002 RBRVS brochure on the AAP website.).

Welcome New Members

Paul G. Barongan, MD	Oak Ridge
E. Heather Fairbank, MD	Nashville
Jodi Burton Gage, MD	Johnson City
Robert Higginbotham, MD	Memphis
Wendy L. Hitch, MD	Hermitage
Kasey A. Huff, MD	Collierville
Carle Crane Kalsi, MD	Memphis
Rebecca Ruby Powers, MD	Johnson City
John Proctor, MD	Nashville
George William Robertson, MD	Lebanon
Katherine Tun, MD	Chattanooga

Please Welcome Your New and Newly Elected Board Members

John C. Ring, MD, President (Memphis)
David K. Kalwinsky, MD, Vice-President (Johnson City)
J. Michael Connors, MD, Secretary-Treasurer (Knoxville)
Martin I Herman, MD, Fellow At-Large, West TN (Memphis)
Patricia C. Davis, MD, Fellow At-Large, Middle TN (Columbia)
Charles L. Campbell, MD, Fellow At-Large, East TN (Oak Ridge)
Robert B. Lembersky, MD, Program Chair (Knoxville)
Mary E. Keown, MD, Membership Chair (Nashville)
Elizabeth M. Andrew, MD, Nominating Chair (Memphis)
Tomasz H. Voychehovski, MD, Pres., Hamilton County Pediatric Society (Chattanooga)
Patrice Reed, MD, Pres., Memphis Pediatric Society (Memphis)

Membership Dues

Invoices for your FY03 dues will be sent to you in May from the AAP, which we contract with as our dues billing service. Those dues will cover the period of July 1, 2002 through June 30, 2003. Please note that while both national and state chapter dues are on the same invoice, you are not obligated to be a member of both. However, we sincerely hope that the significant growth and accomplishments of your TN Chapter over the past year will warrant your renewal to your state Chapter in addition to your national membership.

Thank you!

UPCOMING WORKSHOPS

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District IV Chair Commentary
...continued from page 1

in the predicament of being the biological child of a gay/lesbian custodial parent. These children do not have access to a traditional family unit, and we pediatricians must help them make the best of a difficult situation. The AAP cannot, as a public policy organization, say that a given adult is unfit to be a parent simply based on the sexual orientation of that adult. We all have learned that all children need as many responsible adults in their lives as possible. Most adoption procedures require the adopting adult to prove that he/she is really worthy of being made a legal parent/guardian of the child. The AAP was simply trying to say that gay/lesbian partners of gay/lesbian biological parents should have the right to adopt the children of those biological parents. If I had been asked to approve the documents in question, I would have approved them. However, I think the AAP Fellows who have complained to me about the documents have made one point absolutely clear: that the AAP has spent an enormous amount of time and energy on a "fringe issue" as it relates to the American family. The AAP has failed to do anything substantial to publicly promote the value of the traditional family unit for the average child. It will be my task, as your representative on the Board of Directors of the AAP, to focus the Board on addressing the fact that the American family is in crisis and that pediatricians are in positions to improve the health of children by increasing the number of children who grow up in traditional family units.

When I became Vice President of the NC Chapter of the AAP in 1990, and attended my first Annual Chapter Forum (annual meeting of the AAP leadership), I recall a resolution that asked the AAP to study the growing numbers of single-parent families in America, and further asked the AAP to promote the value of the traditional family unit to the average child. The AAP leadership, which included all the chapter vice presidents and presidents, could not pass this resolution because it appeared to say that single parents were bad parents. District IV continued to rewrite this resolution until it finally passed, several years later, and was referred to the AAP leadership for further action. When Joe Zanga, then of District IV, became President of the AAP, Joe appointed a Task Force on the Family to study family issues and develop a report for the Board of Directors. Joe appointed the original author of the single parent resolution to the Task Force.

The Report of the Task Force, in draft form, arrived on my desk during the furor that erupted after publication of the Coparent Adoption documents. This report is loaded with data to support the value of the traditional family unit to the average American child. This report is on the agenda of the Board of Directors for the upcoming May meeting. It is my hope that the AAP leadership can utilize this report to tell the public and the membership what we already sense is happening to families in America, and the devastating effects these changes are having on our children. I firmly believe that children deserve to be born into a loving family that consists of two legally married heterosexual adults who are committed to stay together "for better or worse" so that their children will have the best chance to grow up to be responsible, productive adult citizens. I fully understand that there are aberrations galore of the traditional family unit and that we all must scramble every day to help those at-risk children do the best they can in these difficult family situations, such as the gay/lesbian dilemma that started this discussion. However, the AAP must help us and the public focus on what is really best for children in these very difficult times, and I sense that our membership feels a bit betrayed by the AAP when it comes to family issues. I think we can all do better. I welcome your advice on this and any other child health issues.

EPSDT Contract with TennCare Continues

Ruth E. Allen, EPSDT Coordinator

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We were successful in renewing our Early Periodic Screening, Diagnosis and Treatment (EPSDT) contract with TennCare through June 30, 2002 and hope to obtain a 12-month contract for the fiscal year beginning July 1, 2002.

We are continuing to meet with state officials to share pediatricians' concerns about TennCare and to improve access to care for children in Tennessee. As we work with the state to improve EPSDT screening rates, one of the key focuses of our activities during the first quarter of 2002 is to obtain data from the state. We are working with the state to obtain information such as:

- ✔ network deficiencies by specialty type and geographic location;
- ✔ average TennCare reimbursement by CPT code, (we hope to obtain in order to compare to the AAP's South Central Average as published in the Medicaid Reimbursement Survey, 2001);
- ✔ results from the state's audits of primary care physician offices on the completeness of documentation regarding the seven components of EPSDT screens (see article on page 10); and
- ✔ the percentage of children who are receiving screens by age group and by geographical location.

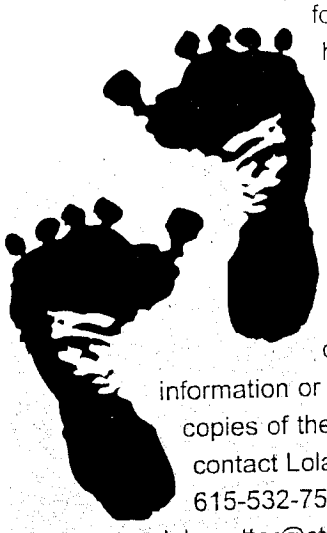
Other key activities this quarter have included:

- ✔ We have established an EPSDT forms committee (chaired by Iris Snider, MD) to maintain the age-specific EPSDT documentation forms to be used in pediatric offices (these forms have been well-received by the majority of our members).
- ✔ I had the opportunity to visit my Medicaid counterpart at the Georgia AAP Chapter to observe and share successes and challenges.
- ✔ I have continued to represent TNAAP in various state meetings including the EPSDT work group (with MCO representation), meetings with the Children's Health Initiative, providing input regarding the EPSDT public awareness campaign, etc.
- ✔ We have established a contact person to address issues as they arise with local health departments providing EPSDT services. (See article on page 9.)
- ✔ I am working with various agencies to obtain information on best practices across the country for outreach to parents to get their children in to their doctor's office to obtain preventive health screenings.
- ✔ I have participated in various HIPAA trainings, and we have begun compiling resources to aid members in becoming HIPAA compliant.
- ✔ We continue to stress the importance of eliminating "hassle factors" in TennCare (for example, we are still working on the issue of a common referral form). We are also helping the state understand barriers to making behavioral health referrals.

How can I help you? Do you have issues in your office that relate to EPSDT? Do you or your staff need additional training about the EPSDT services or documentation requirements? Are you having billing problems with certain MCOs for EPSDT services? Please contact me if I may be of assistance.

EPSDT Public Awareness Campaign

As part of the state's initiative to increase EPSDT screens, they have launched a public awareness campaign called "Tennessee Caring for Kids". You should have received a letter from TNAAP in February notifying you about this campaign and providing you with copies of the informational poster and brochures. If you did not receive this information or if you need additional copies of the materials, please contact Lola Potter at TennCare at 615-532-7542 or lola.potter@state.tn.us.



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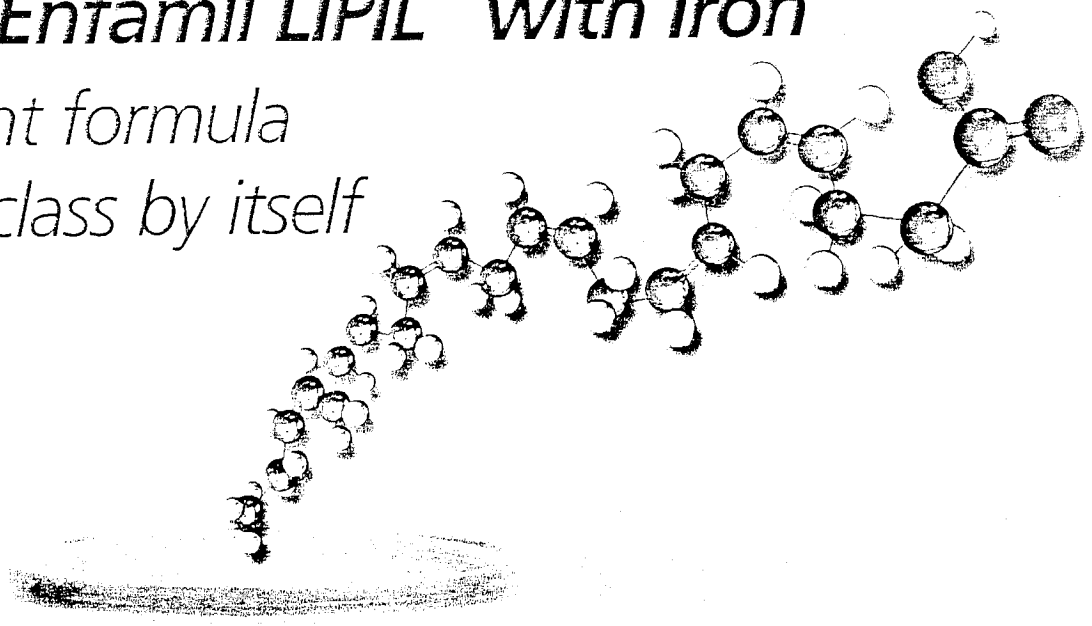

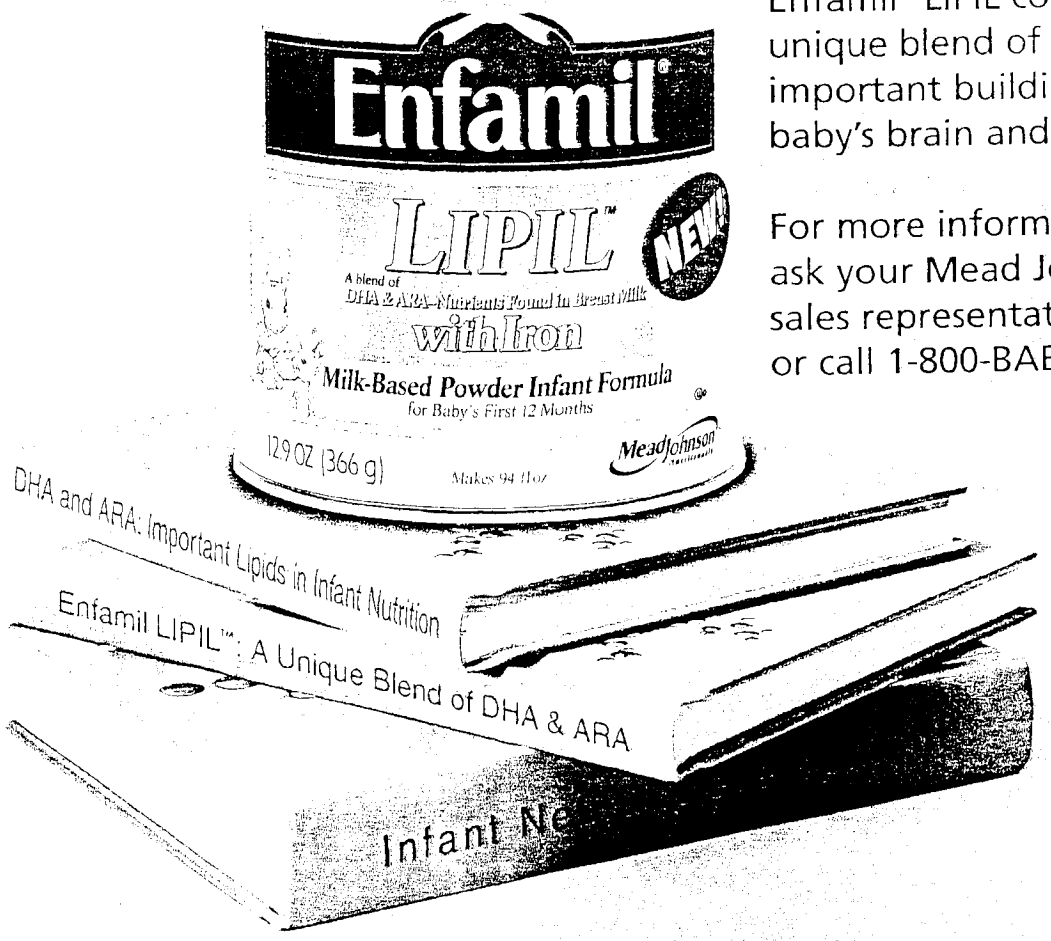

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References: 1. Birch EE, Hoffman DR, Uauy R, et al. Visual acuity and the essentiality of docosahexaenoic acid and arachidonic acid in the diet of term infants. *Pediatr Res.* 1998;44:201-209. **2.** Birch EE, Garfield S, Hoffman DR, et al. A randomized controlled trial of early dietary supply of long-chain polyunsaturated fatty acids and mental development in term infants. *Dev Med Child Neurol.* 2000;42:174-181.

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